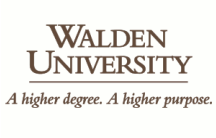

2019

Experiences and Attitudes of Older Homeless Women Toward Healthcare Access

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This is to certify that the doctoral dissertation by

Mary Ann Mueller

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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2019

Abstract

Experiences and Attitudes of Older Homeless Women Toward Healthcare Access

by

Mary Ann Mueller

MBA, University of Phoenix, 2009

BS, University of Phoenix, 2007

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

School of Public Health – Community Health

Walden University

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Abstract

Homelessness among older women is a growing problem in many metropolitan areas of the United States. Researchers have indicated that health issues and problems accessing basic care are connected. Older homeless women face increased health issues, multiple challenges related to accessing basic care, and low incomes which put them at higher risk of becoming homeless, staying homeless, and delaying medical treatment. The homeless who lack fulfillment of social support and timely medical care are considered repetitive users of the emergency department and hospital stays. The purpose of this phenomenological study was to explore the experiences and beliefs of older homeless women with system access. The research questions were focused on what the study participants knew about healthcare system access, their personal experiences, and linked uses of access with healthcare services, as well as, negative barriers and enablers. Guided by the theory of disengagement, face-to-face in-depth interviews with 12 homeless women ages 45 and above was performed. Content analysis was used to analyze responses from interviewees. Findings included the lived experiences and beliefs regarding healthcare services linked with personal health, barriers related to healthcare services, and enablers toward healthcare access. The results of this study produced needed insights on how to shift public and persuasive support methods to meet changing health needs and desires of older homeless women. This study may lead to positive social change through gained knowledge of the personal experiences, beliefs, attitudes, and perceptions of older homeless women.

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last month of quarter you plan to graduate 2019

Dedication

First and foremost, this dissertation is dedicated to all the homeless women I have met during this study that will help many in the future tell their story from different perspectives on an unpredictable path of life. My gratitude is immeasurable for their time and trust. I would like to also dedicate this dissertation with love to all my beautiful daughters: Milicent, Hattie Mae, Myra, and Mona. You have all been a source of inspiration and encouragement throughout my life.

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To Milicent, for encouraging me to go back to school later in life. To Hattie Mae, for life altering and encouraging words to recreate me. To Myra, for pointing me in the direction of Public Health and taking the time to proofread my writings when asked. To Mona, for the wide range of assistance provided from beginning to end and for encouraging me not to give up.

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Chapter 1: Introduction to the Study

Introduction

Homelessness is a growing problem in many metropolitan areas of the United States. Being homeless generates higher health risks and other barriers to health care than for the general population (Brown, Kiely, Bharel, & Mitchell, 2012; Waldbrook, 2013). Currently, women are one of the fastest growing groups among homeless populations (Knopf-Amelung, 2013; Schaefer Solle, 2015). Older homeless women are a specific subset of the homeless population in need of specific research to determine their beliefs and perspectives on access to timely medical care. The unmet health care needs of older homeless women and other vulnerable populations continue to be a high priority for public health.

Homelessness presents added challenges for adults in need of timely medical care. Often homeless individuals will delay seeking medical attention until health issues reach emergency care levels (Donovan et al., 2010; Huynh, 2015). Since a large number of older homeless women are not accessing the health care system promptly, the death risk becomes higher than it does for the general population of aged women (Donovan et al., 2010). There is a gap in understanding why homeless women do not seek health care services even when available in their areas.

Although various programs exist that provide services for the homeless on national, state, and local levels, current studies exist that identify a lack of information. There remains a need for focus on the personal experiences, beliefs, and attitudes on health care access among older homeless women (Hall, 2010; Knopf-Amelung, 2013; Mautner et al., 2013; Waldbrook, 2013).

Nationally, approximately 633,782 people were counted as homeless on one day during a seven-day period in 2013 (U.S. Department of Housing and Urban Development, 2013). However, the percentage of aged women is unknown with many having unknown ethnicities (WHO, 2015).

More recently, the Annual Homeless Assessment Report (AHAR, 2013) and The U.S. Department of Housing and Urban Development (HUD. 2013) noted that among the much homeless, 67.3% were 25 years and older. Older women are a sub-group among homeless populations that have not been given ample specificity to boost changes related to health care system access (Maness & Khan, 2014). In 1976 federal support was merged with health sponsored health care facilities under section 330 of the Public Health Service Act (Davis & Schoen, 1978). A report from the House Office of the Legislative Counsel (2017) stated that amendments to section 330 of the Public Health Service Act through the P.L. 115–52 in August 2017 included health-related issues for the medically underserved and homeless populations. As the number of older homeless individuals increase with the aging of baby boomers, unique challenges for service providers will also increase the need for improving health care service accessibility to promote healthier living.

Disparities related to health care access are described based on racial, ethnic subgroups, and several other underserved populations with a focus on demographics and health belief factors (Derose, Gresenz, & Ringel, 2011). Through this study, I seek to fill a gap in the research related to older homeless women's beliefs and perspectives on the limited use of available health care and their perceptions related to seeking timely medical attention. Little research is available on how each population perceives their personal needs, challenges or barriers to health care

system access (Knopf-Amelung, 2013). Health issues and problems accessing basic care among older populations is a growing problem (Waldoch, 2013). Older homeless women face with increased health issues, multiple challenges related to accessing basic care, and low incomes which put them at higher risk of becoming homeless and delaying medical treatment (Waldbrook, 2013; Waldoch, 2013). These challenges compound daily living for older homeless women.

Additionally, repetitive users of the emergency department and hospital stays were mostly found among the homeless who lacked fulfillment of social support and timely medical care through the health care system (Brown et al., 2013; Hasselman, 2013; Mautner et al., 2013). Research findings suggest that ED visits and hospital admissions were directly related to periods of instability and stress that stemmed from a young age (Thomas-Henkel, Hendricks, & Church, 2015). To address the gap in literature demonstrating why homeless women do not seek health care services, my plan was to assess the problem by directly interviewing these women on their experiences and attitudes on unmet health needs associated with health care access. The remaining pieces of chapter one include the background, problem statement, purpose of the study, research questions, theoretical framework, conceptual framework, nature of the study, definitions, assumptions, scope and delimitations, limitations, significance, and a summary.

Background

Currently, health care system access presents serious problems for the underrepresented population of older homeless women. Despite the wide-ranging awareness of homelessness, there remains a need in the United States for specific information that will convey their personal

experiences, beliefs, and health needs. The United States' homeless population continues to age and increase (Brown, Thomas, Cutler, & Hinderlie, 2013; Knopf-Amelung, 2013; National Alliance to End Homelessness**,** 2015). Future projections from the U. S. Census Bureau anticipated that older populations would double by 2050 generating an 89 million populace of older individuals with a 33% increase in homelessness by 2020 which averages out to be approximately 95,000 expected homeless over upcoming years (Knopf-Amelung, 2013; Sermons, & Henry, 2011). These numbers increase already growing problems among the homeless and for policymakers.

Increasing and prolonged health problems among older homeless individuals continue to be a growing problem. Those who do not use health care access early put themselves at higher risk for acute health problems and death (Brown et al., 2016; Brown et al., 2013; Grenier, Barken, Sussman, Rothwell, & Lavoie, 2013; Waldoch, 2013). Public health plays an important role in understanding, developing and implementing resolutions to health care disparities, access, and quality. Factors such as environment, safety, human health, and well-being directly link to the basic principles of public health (Derose, Gresenz, & Ringel, 2011). In essence, with the efforts of public health to help the homeless population as a whole, there needs to be more specifics that can identify individuals by age, ethnicity, and gender to recognize gaps in system access among older women.

Historically, the invisibility of older homeless individuals and growing health risk is largely due to inadequate and limited focus on general homelessness in literature. Women are grossly underrepresented in literature (Cohen, 1999; Grenier et al., 2013; Knopf-Amelung, 2013;

North & Smit, 1993; Philipps, 2012; Rossi, 1990). A current study on health and health care system access indicated growing declines for medical treatment and increases in ED visits among older individuals with low or no insurance coverage (Kenney, McMorrow, Zuckerman, & Goin, 2012). As a general rule, when sick people are not aware of available options or do not understand how to exercise those options, they will often wait until the only option is to seek help through a popular means such as the ED.

Gaps in literature indicated unmet needs were associated with health and health care system access; revealing a growing need for better programs focused on the vulnerability of older homeless women (Sermons & Henry, 2011). Furthermore, current developments of health care access frameworks to date has not adequately theorized or deliberated on how the proficiency of public health operations can impact health care access (Derose, Gresenz, & Ringel, 2011). One of the biggest issues faced by older homeless women is significant challenges understanding the protocols for the use of health care services and health care system access. Existing literature shows similarities with limited system access among older homeless women and other homeless populations (Knopf-Amelung, 2013; Mautner et al., 2013; Waldbrook, 2013. Other links included high ED and hospital admissions, accelerated and prolonged illnesses, resulting in negative relationships with health care providers and workers (Donovan et al., 2010; Hall, 2010; Knopf-Amelung, 2013; Nolan, 2011; Petersen & Jones, 2012; Waldbrook, 2013). There is a genuine need among older homeless populations for the public health core functions and essential services to be unified with system access functions, processes, and developments

(Derose, Gresenz, & Ringel, 2011). To address disparities that directly affect homeless older women collaboration between health care system leaders and public health can greatly help.

Confusion and feelings of rejection appear to be key factors for the lack of health care system access among older homeless women (Bekhet, Zauszniewski, & Nakhla, 2008). Feelings of loneliness and frustration may also cause older homeless women to make unhealthy decisions and delay seeking available services (Bah, 2015). Overall, the representation of research needs solid examples of personal experiences that will produce multiple calls to action with responses and reactions from decision makers.

Predisposing factors correlate with demographics, health beliefs, and other characteristics; while enabling and need factors correlates with health insurance, income, family, community resources, illnesses, and health status (Derose, Gresenz, & Ringel, 2011). The growing and prolonged health issues among older homeless women validate the predicted outcomes applicable to Andersen and Newman's (2005) concepts of factors related to increasing problems with accessing the health care system. Older homeless women may be able to provide additional information that will help researchers and practitioners become better advocates to assist this population. Thereby, promoting increases in participation in accessing the health care system. With the inclusion of communities, social networks, and civic entities a better understanding can be gained on links between health care system non-use and perspectives of older homeless women (Oudshoorn et al., 2013; Waldbrook, 2013).

Research suggests there is stagnant and limited use of health care access among aged populations, therefore implying links to discouraging experiences and disengagement (Brown,

Kiely, Bharel, & Mitchell, 2012; Gulbrandsen, & Walsh, 2015; Vijayaraghavan et al., 2012). Poor relationships with healthcare providers, prolonged pre-existing illnesses, and developing health issues are evident among this population. The absence of routine medical treatment intertwined with disengagement, the low percentages of health care system access continues to escalate (Thomas-Henkel, Hendricks, & Church, 2015; Waldoch, 2013; Hasselman, 2013; Mautner et al. 2013; Tallmer & Kutner, 1969; Cumming & Henry, 1961). Similarly, trusting relationships with positive support from within the U. S. government, medical facilities, and public health will activate partnerships and support from older homeless women.

Problem Statement

Older adult, homeless women have significant challenges accessing health care. While health care leaders and policymakers struggle with how to provide health care to special populations, there is little research on how each population perceives their needs, challenges or barriers to health care access (Knopf-Amelung, 2013). Current health care access frameworks do not adequately theorize or deliberate on public health and how it can impact health care access (Derose, Gresenz, & Ringel, 2011). There is a gap in the literature related to perspectives on how older homeless women access health care and feel about seeking health care.

Purpose of the Study

The purpose of this phenomenological qualitative study was to gain an understanding of the thoughts and perspectives of older women who are considered homeless toward their access and use health care services. This study was interested in the personal experiences, beliefs, and attitudes of older homeless women toward health care access. Other interest includes

perspectives on unmet health needs linked to access. This study will also explore the perspectives of older homeless women and what they say are needed for health care access.

Research Questions

RQ1: What are the beliefs and perspectives of older homeless women toward health care access?

RQ2: What do older homeless women believe are barriers to accessing health care?

RQ3: What do older homeless women perceive as enablers toward accessing health care?

RQ4: How do older homeless women perceive the personal use of health care services and links to their health?

Theoretical Framework

Perceptions and experiences of older homeless women will be the primary focus and show relevance to two theories. Andersen's (1968) theoretical behavioral model of health care services was used to predict the unmet health needs of older homeless women (Gelberg, Andersen, & Leake, 2000) and Cumming and Henry's (1961) disengagement theory that postulates withdrawal from society is a natural stage of life for older individuals. The health care access framework alludes to the behavioral model of health services used in this study on older homeless women and health care system access to help facilitate understanding (Derose, Gresenz, & Ringel, 2011). Andersen's theoretical behavioral model of health care services can also facilitate explanations on individual use, care of health care providers, and service access.

The Andersen's theoretical behavioral model of health care services framework includes three dissimilar factors that can separate the different measures of possible access: predisposing, enabling, and needs. Additional components include the ability of the system user to differentiate

between system access measures, such as measures of utilized access. Other enhancements to the model include health behavior, personal beliefs, health outcomes, and patient and service satisfaction. As well as, environmental influences, vulnerable populations, and behaviors related to health and outcomes (Derose, Gresenz, & Ringel, 2011; Hochbaum, Rosenstock, & Kegels, 1952; Rosenstock, 1974). Other aspects of a health care access framework include concepts that concentrate on the inclusion of impartiality, efficiency, significance, physical health, and well-being. To date, the most widely used framework for understanding individuals' access to health care services is the Andersen Behavior Model of Health Services.

Current literature revealed that predisposing factors reveal links with older homeless individuals (Brown, Thomas, Bunolna, 2015; Chambers et al., 2013; Cutler, & Hinderlie, 2013; Derose, Gresenz, & Ringel, 2011; Hasselman, 2013). For instance, limited healthcare system access, high rates of ED and hospital admissions and health education issues all accelerated and prolonged illnesses (Brown, Thomas, Bunolna, 2015; Chambers et al., 2013; Cutler, & Hinderlie, 2013; Hasselman, 2013). As well as, negative relationships with health care providers and health management workers (Doran et al., 2014; Hamilton, Poza, & Washington, 2012). Notably, health beliefs highly influence personal behavior based on social connections, age, gender, ethnicity, and education (Ljoma, 2013). Additionally, other literature showed that frequent ED visits and hospital stays were directly related to periods of instability and stress that stemmed from a young age (Thomas-Henkel, Hendricks, & Church, 2015).

The enabling factors related to older homeless women also include access to health care such as through public health services and the provision of health insurance. Other areas include

choices of health providers, ample government support, feasible income, employment. Additionally, tax breaks for assisting families are needed to help with the livelihoods of the homeless and a need for lower rates of ED use (Chambers et al., 2013; Dhemba & Dhemba, 2015; Vijayaraghavan et al., 2012). Also, pain management provision and education are needed for the homeless and can lead to adequate and timely system access to lessen paramount factors (Bunolna, 2015; Doran et al., 2014; Ljoma, 2013).

The need factors used are based on health risks related to medical diagnoses, such as diabetes, cardiovascular ailments, obesity, infectious diseases, and sexually transmitted infections, and many other health risks (Vijayaraghavan et al., 2012). Other needs to be considered related to relationships from early life issues, educational illiteracy, and social links attached to emotional problems. Other areas will be related to how simple exchanges between the homeless and care providers can change how the homeless view the healthcare system when changing needs are understood and met.

Differences involved trust issues between the homeless, provider, childhood experiences and effects of health (Thomas-Henkel, Hendricks, & Church, 2015; Waldbrook, 2013; Irwin, 2011). Health needs in literature were also considered multifaceted and not easily met (Bunolna, 2015). Individuals who have diverse experiences with similar or same health challenges will have different needs (Brown, Goodman, Guzman, Tieu, Ponath, & Kushel, 2016). The lack of available literature on older homeless women, evidence further need for identifying the impact of frailties among older homeless individuals (Salem, Nyamathi, Brecht, Phillips, Mentes,

Sarkisian, 2013). Homeless need factors and health system factors coincide when providers and patients agree with services rendered.

The Andersen's theoretical behavioral model of health care services framework also includes additional aspects related to vulnerable populations, such as the concept of influential outside sources. Also, health policies that directly affect the underserved in need of ongoing medical attention were evident (Derose, Gresenz, & Ringel, 2011). Life for older individuals can evidence declines in physical activities and ego-driven functions tied to social relationships, new behaviors, and hierarchal changes (Crossman, 2016). Current studies show that increased health risk and death can be initiated and motivated by social isolation among older individuals (Dickens et al., 2011). Social disengagement puts older homeless individuals at greater risk for isolation for needed health care.

The literature further suggested that beliefs, personal choices, and the process of withdrawal from the public and social influences are a natural part of growing old (Hernandez & Blazer, 2006; Singh & Misra, 2009; Tallmer & Kutner, 1969). Specifically, literature revealed that homeless women suffer from negative social encounters, challenges with simple daily physical and mental functions, and withdrawal from accessing routine healthcare (Schaefer Solle, 2015). Differences are that disengagement is a natural and essential function of aging and not necessarily linked to nonuse of system access (Tallmer & Kutner, 1969; Cumming & Henry, 1961).

Additionally, disengagement theory directly links anxieties and low morale with forced circumstances and lifestyles (Tallmer & Kutner, 1969; Cumming & Henry, 1961). Older adults

with social vulnerabilities and isolation were at a heightened risk for homelessness. Health challenges include varying degrees of predisposing, enabling, and need factors directly related to health beliefs (Brown, Thomas, Cutler, & Hinderlie, 2013; Burt, Aron, Lee, & Valente, 2001; Derose, Gresenz, & Ringel, 2011). Overall, instigated social structures and rejection is the primary reasons that older homeless women and men disengage and withdraw from society. Disengagement theory is also linked to the social and psychological nature of older persons and has been proven over time to be a critical component for further research on gerontological studies (Maddox, 1964). Regression of health and social relationships among older individuals occur on multiple levels as they age **(**van Groenou, Hoogendijk, & van Tilburg, 2013). Homeless situations for older women need personalized approaches that can help them engage in interventions that focus on increased use of health care system access that they feel will be useful and suitable for them (Coles, Themessl-Huber, & Freeman, 2012). Specialized attention is needed for this population to offset past negative perceptions associated with health care system access to building understanding and safe attachments to health-related experiences.

Figure one below shows public support exchange links to the aged homeless women's wants, needs, and changes to exchanges of a persuasive support.

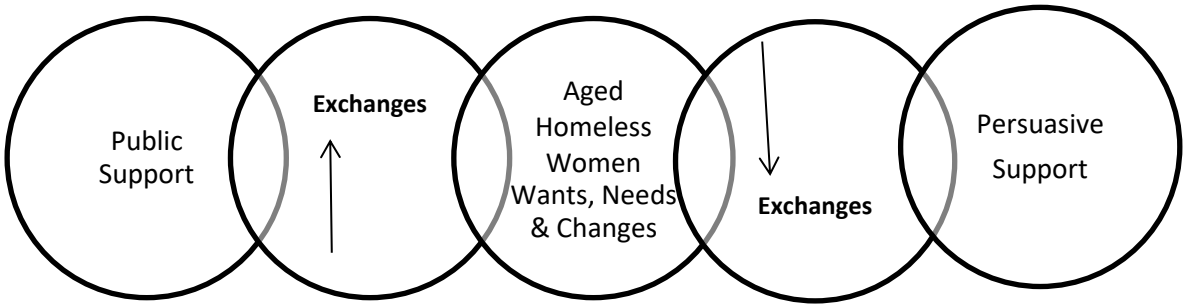

Figure 1. Circle Process used to show sequential steps of the theoretical framework model of health care services.

Figure two below reveals the central idea of unfavorable outcomes linked to homelessness, health factors, health choices, and health system policies.

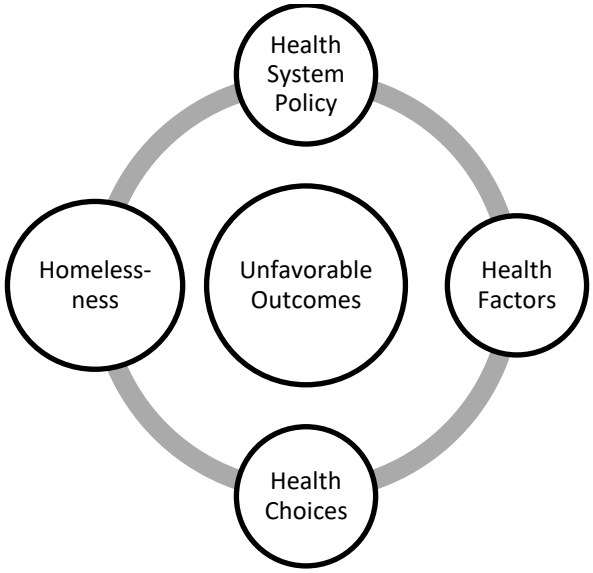

Figure 2. Radial Cycle used to show relationships to the central idea.

Conceptual Framework

In the 1960's Andersen's behavior model was created around the management of care with an objective to predict and explain how an individual used health care services (Aday, & Andersen, 1974; Fox, 1972; McDonald et al., 2007; Rogers, 1973). The conceptual framework of the model uses predisposing features and enabling resources together to illustrate the point of view effects of various levels of system limitations and an individual's ability to use and respond to care management needs. The needs concept of care management focuses on the individual

their physical health, personal functionality, beliefs, and perception of needs. Overall the combined predisposing and enabling factors would assess opportunities and barriers to changes in behavior and beliefs (Derose, Gresenz, & Ringel, 2011; McDonald et al., 2007).

The Affordable Care Act was implemented to increase the national quality of care and to ensure multiple options for all societies (Viveiros, 2015). Furthermore, the health care access framework was theorized based on investigations of health policy objectives and the operational system of health care (Aday, & Andersen, 1974). These objectives applied to anyone at risk to predicted outcomes; how they related to utilization, their satisfaction of system access, and the actual services rendered were also significant factors (Aday, & Andersen, 1974; Fox, 1972; Rogers, 1973).

The Andersen behavioral model is used to help the problem at hand with health care system access for older homeless women. Benefits of behavioral models can be used to facilitate understanding related to experiences and attitudes toward health care access (Derose, Gresenz, & Ringel, 2011). Other attributes of the behavioral model are the concepts that focus on the inclusion of equity, effectiveness, significance, physical health, and well-being, as well as predisposing, enabling, and needs that address both health and shelter needs (Derose, Gresenz, & Ringel, 2011; Maslow, 1943). This particular type of framework also addresses other aspects associated with vulnerable populations and focuses on the concept of influential outside sources such as health policies that directly affect the underserved in need of ongoing medical attention.

Nature of the Study

This study had a qualitative phenomenological focus and illustrate the perceptions and beliefs of older homeless women in an attempt to explain why they do not access the health care system promptly and routinely, which was the primary focus of this dissertation. Concentration was on three system access experiences. The focus began with attention to their recall of initial experiences. Secondly, emphasis was on details about current experiences, beliefs, and feelings, with examples. Lastly, emphasis was also focus on probing into the meaning of their experiences and beliefs.

Definitions

Accessing health care: The health care system access (Derose, Gresenz, & Ringel, 2011).

Homeless: Section 330(h)(5)(A); an individual who lacks housing (National Health Care for the Homeless Council, 2017).

Older adult: Even though there was no set starting point to define an age for older adults, calendar years and biological age are appropriate for ages ranging from 45 years and above (Petry, 2002; WHO, 2016).

Special Populations: Individuals with greatest health risks and have social challenges (Akerlof et al., 2015).

Assumptions

The following assumptions informed this study on older homeless women:

1. There will be enough older homeless women to interview.
2. Participants will fully understand questions.

3. Participants will give honest answers based on their experiences, beliefs, and assumptions.

4. I will have access to any required interview information and materials before initiating any discussions.

Scope and Delimitations

This study will be narrowed in scope through a phenomenology course of study and chosen because of curiosity about the experiences, beliefs, and attitudes of older homeless women toward health care access. The types of persons focused on for this study are older homeless women in Maricopa County Arizona. Geographic inequalities associated with accessing health care services will be acknowledged (Delamater, 2012).

The strategy for using frameworks will also support purposeful sampling that will allow rigorous focus on these women and help me obtain rich insights into their personal experiences' beliefs, and attitudes (Patton, 2015). Furthermore, The Arizona Department of Economic Security (AZDES, 2011) reported that the Maricopa County homeless population based on race was 68%, White, 22% Black, 5% Mixed Race, 4% Native American, and 1% all other races. These percentages included men women and children, which motivated my reasons for not focusing on any one particular race or ethnicity. Exclusions from the study will include homeless women who are pregnant and 44 years old and under (within childbearing age), (CDC, 2016). Additionally, by choosing a phenomenological study, it allowed me to use criterion sampling and select participants who closely match the criteria for my study throughout Maricopa County (Rudestam, & Newton, 2015).

Limitations

Limitations of this study included qualitative research that was out of my control, such as exactness because qualitative research is hard to prove and assess, as well as the need for large volumes of data that limits time and cause constraints (Anderson, 2010). My physical presence was also considered because negative reactions from participants could be motivated by perceived confidentiality issues. Obscurity during reporting and characterizing visual findings can also cause limitations. Finally, limitations will be evident that affect social situations, finances, and replications.

Significance

This research attempted to fill a gap in understanding by focusing on the perspectives and beliefs of older homeless women. This project was unique because to date the most widely used framework for understanding individuals' access to health care services is the Andersen Behavior Model of Health Services. This model addresses an under-researched area of health care access among older homeless women (Derose, Gresenz, & Ringel, 2011; Ellison, 2013; Hall, 2010; Kliger, Sharam, & Essaber, 2010; Nolan, 2011; Vijayaraghavan et al., 2012; Waldbrook, 2013). The results of this study provided needed insights into the low percentages of timely health care access (Chambers et al., 2013; Huey et al., 2014; Rossman & Rollis, 2003). This study was also significant to policymakers, practitioners, and researchers on how to succeed in helping older homeless women increase timely access to the health care system. As well as, add enhanced highlights to public health outcomes that can be directly associated with health care access.

This study was also significant to public health professionals because limited research was available on homelessness in Arizona. Existing research is relatively standard for acknowledging an overwhelming problem with homelessness in general, such as situations specifically associated with daily living and health challenges for younger homeless populations. Moreover, with many outreach facilities for the homeless in Arizona, there appeared to be nothing available that specifically focuses on health issues of older homeless women or their challenges with health care system access. Arizona uses a point in time (PIT) program which calculates the number of individuals during any one night of the current year. In 2015 the Arizona Department of Economic Security (2016) reported 2,270 homeless individuals from among all age groups, ethnicities, and both genders; 2014 accounted for 2,500 homeless individuals revealing substantial increases among homeless populations.

Additionally, this study was significant to health care leaders because older homeless women are unaccounted for due to there not being any real associated census identifying ethnicities or demographics on state or national levels. The U.S. Department of Housing and Urban Development (HUD, 2014) report publicized that women of all ages and nationalities were unidentified among homeless subpopulations. The United States Census Bureau (2012) earlier reported that availability of information related to emergency room visits by homeless individuals and the use of transitional shelters was limited. As well as, confusing and lacked the useful information needed for statistical data. A recent study (Knopf-Amelung, 2013) noted that older homeless populations would double by 2050 (Dhemba & Dhemba, 2015) generating over

an 89 million populace of older homeless individuals with a 33% increase in homelessness by 2020 which averages out to approximately 95,000 homeless.

Motivators for positive social change involve broadening understanding and engaging decision makers in worthy causes where societal imbalances are evident. Public health organizations and agencies depict various ways to identify and address disparities in health care access (Derose, Gresenz, & Ringel, 2011). Since a large number of older homeless women are not accessing the health care system promptly, burgeoned situations put them at higher risks of death over the general population of older women (Donovan et al., 2010; Huey et al., 2014; McInnes, Li, & Hogan, 2013). Supporting increased activity for health care access can promote improved health, encouragement, and manageable life balance (Donovan et al., 2010; Oudshoorn, et al., 2013). This study will help improve policies on homelessness and inconsistencies among women in general and evidence a necessity for further research on older women's experiences and attitudes.

Finally, this study was significant to policymakers as a point of reference for recommendations regarding strategies that will facilitate needed changes in decisions to create and improve existing policies associated with older homeless individuals and health system access. For example, policies to address Arizona's uniqueness because of the many remote and desert areas which are attributable to hard to find individuals, multiple assistance provision issues, revisions to eliminate confusion when performing head counts, and better ways to characterize homeless groups (Hedberg & Hart, 2013).

Changes in the current mode of resolutions along with newer policies can address fragmented pressure to set, meet, and maintain objectives that focus on homeless populations, in general, to include the much-needed attention to gender, age, and ethnicity in Arizona. Furthermore, older homeless women need special considerations while living in constant fluidity that leaves them lacking in any form of stableness making it difficult to build helpful parameters to medical care (Grenier, Barken, Sussman, Rothwell, & Lavoie, 2013; Mott, Moore, & Rothwell, 2012). Overall, without an adequate amount of attention from decision makers the special health needs, specific identifiers, and system access issues of older homeless women will remain undocumented.

Summary

Chapter one described the development of understanding and exploring the lived experiences of health care system access among older homeless women. In this study, I sought to gain an understanding of the effects of limited and non-use of access to care as well as predicted health outcomes, and it explores the impact on participants, their perceptions, beliefs, and expectations. The age range for the study population was 45 and older, with research questions developed to capture the perspectives of older homeless women toward health care access and their perceived barriers to accessing health care, as well as their perceptions on the personal use of health care services as linked toward their health.

The location for the study in Maricopa County in the state of Arizona with consideration given to geographic inequalities. Review of the literature focused on explanations of older homeless women limited used of access to health care and their perceptions related to seeking

timely medical attention about the significant challenges they face when accessing the system. My objective was to gain an understanding of the thoughts and perspectives of older women who are considered homeless and toward how individuals may access or use health care services, with additional attention given to the significant health challenges they encounter on a regular basis while being homeless.

Chapter 2 will provide an outline of the strategy used to review literature, explain the theoretical foundation and conceptual framework, as well as describe literature reviewed with key concepts. Chapter 3 will discuss a sequence of procedures that explain the research design and rationale, the researcher's role, methodology, issues of trustworthiness, ethical procedures, and the data analysis plan in detail.

Chapter 2: Literature Review

Introduction

The search strategies used to secure needed research and resources include a conceptual framework, a theoretical foundation, the literature reviewed articles, books, databases, health and homeless-related keywords and websites. The theoretical foundation for this study will be from Andersen's behavioral model of health services developed in 1968 to answer why people used health services (Andersen, 1995). Later another model was developed in the 1970s that focused on policies, available resources, and health service organizations, which included patient satisfaction (Andersen & Newman, 1973). The model was then extended to include evaluated and perceived health status with the added element of public health prevention. Finally, the model was iterated to focus on the individual and access processes with emphasis on health outcomes and the gradation of health changes (Newhouse, 1993). Public health plays an important role in understanding, developing and implementing resolutions to health care access, disparities, and care quality. Factors such as environment, safety, human health, and well-being directly linked to the basic principles of the public health model (Derose, Gresenz, & Ringel, 2011).

Another theoretical foundation was from a disengagement theory created by Cumming and Henry in 1961 to address processes of aging and because of controversies that motivated further research on social relationships and social roles among the aged (Crossman, 2016). In 1961Cumming and Henry postulated that disengagement is a natural and preferred behavioral function for aged individuals. Whereas known sociologists such as Hendricks, 1994; Hochschild,

1975; Hooyman & Kiyak, 2011; Maddox, Jr, 1964; Parsons, 1966; Williams & Wirths, 1965; suggested that because society projects inequality to rights and resources, disengagement among the aged is not a personally chosen behavior.

Literature Search Strategy

Chapter 2 presents previous and current research that reveals connections of the proposed study. The first phase of the search strategy consists of the careful reading of abstracts to know if the articles fit with the general aspects of the research and research questions. The next phase of the literature search strategy was a careful reading of multiple sections of the articles to warrant any tentative decisions about the usefulness of the material to confirm that the selections are useful, and that chosen literature supports the proposal.

The available research provided resources from various databases then were identified and used from MEDLINE, SocINDEX with Full Text, PubMed, EBSCOhost, CINAHL Plus with Full Text. Also, ScienceDirect, Title Searches, Google Scholar, Walden Library, ERIC database, and the Cochrane database. ProQuest Nursing & Allied Health Source, PsychINFO, Sage, and Walden Dissertations and Doctoral Studies added to the chosen resources. Topics addressed in this literature covered several categories. Such as, (a) the conceptual framework and theoretical foundation for the study and (b) older homeless women and challenges related to accessing the health care system. Next, was (d) social disengagement, (e) prevalent health issues among this age population, and (f) frequencies associated with high ED use and hospital admissions. Finally, (g) barriers to accessing the health care system, and (h) existing support programs.

The following keywords with health-related results enhanced the search: *system access* (21 results), *barriers to care* (6 results), *disengagement* (13 results), *ED and hospital visits* (11 results), *homeless women and health issues* (67 results). Methodological limitations such as sampling and interview service settings for prior research deficiencies in studies specific to older homeless women after 2012 and self-reported data, created set parameters. Additional resource located at the Department of HUD and the National Alliance to End Homelessness websites proved invaluable. Date ranges for the literature reviewed were articles from as early as 1943 through 2016; comprised of relevant and historical information for this study. Literature searches generated 17,200 scholarly peer-reviewed articles on homeless females and seven books for the literature review and the methodology. Other materials used were books by various authors on public health, health communication, research design, evaluation, and methods.

Theoretical Foundation

This study used two theories. Andersen's (1968) theoretical behavioral model of health care services used to predict the unmet health needs of older homeless women (Gelberg, Andersen, & Leake, 2000) and Cumming and Henry's (1961) disengagement theory that postulates withdrawal from society is a natural stage of life for older individuals. The main reason for selecting these theories is Andersen's behavioral model is the most current development for health care access. To date, and no other framework adequately theorizes or deliberates on how years of research and expertise of public health can impact health care access and address the needs of this population. Additionally, the disengagement theory has expanded over the years and can add richness to this study and was widely recognized and used for health

care system utilization (Gelberg et al., 2002; Huey, Broll, Hryniewicz, & Fthenos, 2014; Ljoma, 2013; Lewis, Andersen, & Gelberg, 2003; Willis, Glaser, & Price, 2010). Another reason for the selection of this study was the concept of barriers and enablers that apply to older homeless women's non-use and use of the health care system in Maricopa County in Arizona.

The behavioral model of health care services has been used extensively and is specific for vulnerable populations. Other benefits of the model are for gaining an understanding, explaining access to health care services, and physician care (Babitsch, Gohl, & von Lengerke, 2012; Derose, Gresenz, & Ringel, 2011; Heider et al., 2014). Andersen's behavioral model is an investigative tool used based on various service-related health challenges to show comparisons in health system capabilities and individual health needs, such as fair and poor health with the general population and the homeless (Babitsch, Gohl, & von Lengerke, 2012). Andersen's behavioral model based the original writings on observational and empirical theories. The model was revised over several decades (Andersen, 1968; Andersen, 1995; Andersen, 2008; Andersen & Aday, 1978; Andersen et al., 1983; Andersen & Newman, 1973; Andersen & Newman, 2005). The predictive factors of the behavioral model focus on predisposing, enabling, and need which defines health service use, service inclination, service usability, and need for services as well as access to those services. For example, factors such as predisposing correlate with demographics, health beliefs, and other characteristics; while enabling and need factors correlates with health insurance, income, family, community resources, illnesses, and health status (Derose, Gresenz, & Ringel, 2011).

Literature and research analysis based on the theory of the behavioral model of health care services include previous studies indicating opposing priorities with the utilization of health services leading to barriers for homeless individuals needing medical care showing consistency within the literature. Andersen's behavioral model in predicting optional medical care based on importance resulting in the utilization of fewer health services for homeless persons (Andersen, 1995; Gelberg, Andersen, & Leake, 2000; Gelberg, Gallagher, Andersen, & Koegel, 1997; Lewis, Andersen, & Gelberg, 2003).

Currently, the behavioral model is used to examine predisposing, enabling, and need factors in vulnerable populations. The behavioral model proposes that homeless women with preexisting and current illnesses are at higher risk of acute and chronic diseases. These chronic diseases can result in death. Also revealed was that these minority individuals currently ranked high within the health care access pool and use the ED more often than primary care services (Behr & Diaz, 2016; Huey, Broll, Hryniewicz, & Fthenos, 2014; Vijayaraghavan et al., 2012). Furthermore, the roles of predisposing, enabling, and need factors can be evaluated and connected with frequent ED use (Behr & Diaz, 2016).

Additionally, the Andersen behavioral model of health care services has been revised to incorporate social networks and quality of service to reveal predicted occurrences of applicable factors (Behr & Diaz, 2016). The predisposing factors related to older homeless women based concepts on age, ethnicity, education level, marital status, low and no income, negative family circumstances. Enabling factors affecting this population comprised health care access variables with limited or no health insurance, welfare, and social security benefits. The need factors

informed the study on health risk specific to this population and related findings to both physical and mental health issues.

The Cumming and Henry model of Disengagement theory motivated selection because of it's growing recognition. The theory is also used in research to identify and describe social withdrawal among older individuals. Which considered by Cumming and Henry as a normal stage of aging (Adams, 2000; Bungay, 2016; Crossman, 2016; Cumming & Henry, 1961; Gladis, 2014; Lewallen, 2013; McKenna, 2002; Somers, 1977; Tallmer & Kutner, 1969). The concept of disengagement theory presented nine postulates identifying the inevitable process of withdrawal from society and personal relationships (Crossman, 2016; Lewallen, 2013). Cumming and Henry (1961) suggested that close personal and communal withdrawals are a naturally emotional preprogrammed phenomenon that is part of the life cycle of older individuals but does not address or account for older individuals with unusual circumstances related to homelessness and health challenges.

Conceptual Framework

Ronald Andersen with the addition of multiple colleagues developed, revised, and reiterated the behavioral model of health services use making the model the most extensively accepted theoretical framework currently in use for health care utilization analyzation and prediction (Hoebel, Starker, Jordan, Richter, & Lampert, 2014). In the 1960's Andersen's behavior model was created around the management of care with an objective to predict and explain how an individual used health care services (Aday, & Andersen, 1974; Fox, 1972; McDonald et al., 2007; Rogers, 1973). The conceptual framework of the model uses

predisposing features and enabling resources together to illustrate the point of view effects of various levels of system limitations and an individual's ability to use and respond to care management wants and needs.

The needs concept of care management focused on the individual, their physical health, their functionality, health beliefs, and perception of needs. The wants concept focused on the individual and seamless applications of care and all-inclusive personal experiences from start to finish (McDonald et al., 2007). The combined predisposing and enabling factors assesed the opportunities for care and barriers to care that lead to behavior changes for both the care provider and the patient.

The Affordable Care Act was implemented to increase the national quality of care and to ensure multiple options for all societies and vulnerable populations (Viveiros, 2015). Various public health agencies can help initiate positive effects related to health care access on multiple levels using assessment tools to monitor and examine the homeless population's health status to identify health problems and hazards (Derose, Gresenz, & Ringel, 2011). Furthermore, the health care access framework was theorized based on investigations of health policy objectives and the operational system of health care (Aday, & Andersen, 1974). These objectives applied to anyone at risk to predicted outcomes; how they related to utilization, their beliefs, personal satisfaction of system access, and the actual services rendered were also significant factors (Aday, & Andersen, 1974; Fox, 1972; Rogers, 1973).

The Andersen behavioral model is used to help the problem at hand with health care system access for older homeless women. Benefits of behavioral models can be used to facilitate

understanding related to experiences and attitudes toward health care access (Derose, Gresenz, & Ringel, 2011). Other attributes of the behavioral model are the concepts that focus on the inclusion of equity, effectiveness, significance, physical health, and well-being, as well as predisposing, enabling, and needs that address both health and shelter needs (Derose, Gresenz, & Ringel, 2011; Maslow, 1943). This particular type of framework also addresses other aspects associated with vulnerable populations and focuses on the concept of influential outside sources such as health policies that directly affect the underserved and underrepresented in need of ongoing medical attention.

The Andersen behavior model of health service use can be adapted to work with gerontological research because the study focuses on older women. Other adaptive qualities of Andersen's behavior model of health include contextual and individual level differences that show equal demonstration. Other contextual and individual level differences also relate to inequity in system access to health services. Predisposing, enabling, and need factors can be structured based on an individual sense of belief and experience to reveal equity and inequity in health care system access (Hoebel, Starker, Jordan, Richter, & Lampert, 2014). Positive experiences with health system access are paramount to influence balanced attitudes and better health-seeking behaviors among older homeless individuals.

In many cases, the Andersen–Newman behavioral model of health services is viewed from a theoretical foundation to gain a better understanding of trust factors of older individuals and those in positions of authority who control various resources (Petrovic & Blank, 2015). The Andersen and Newman behavioral model of health service use offer a conceptual basis for

producing answers toward behaviors, attitudes, trust, and development (Petrovic & Blank, 2015). The trust factor between individuals and various types of care providers and attendants can influence progression or regression toward the timely use of system access.

Literature Review

Across the spectrum of homelessness, homeless individuals experience higher burdens of health issues above those with reliable homesteads and private health insurance (Argintaru et al., 2013; McNeil, Guirguis-Younger, & Dilley, 2013). Older homeless men and women experience substantial barriers when accessing health care (Argintaru et al., 2013; Brown, Thomas, Cutler, & Hinderlie, 2013; Kushel, 2012). While women have even higher burdens of health-related challenges, such as those specifically unique to women and aging (Ellison, 2013); older women experience homelessness at a later age than men, especially when faced with lower incomes (Waldbrook, 2013).

The death rate among homeless individuals is excessive, due to misuse of drugs, cancer, and heart disease (Baggett et al., 2013). Older homeless women are not always found on the streets or in shelters. Some manage to find various levels of suitable but temporary accommodations which make them appear risk-free and out of the loop among the sheltered and street homeless (Grenier et al., 2013; Mott, Moore, & Rothwell, 2012). Older homeless women have additional needs related to safety provisions resulting from the uniqueness of their venerability in areas replete with street and shelter violence (Cohen, Onserud, & Monaco, 1992; North, Smith, & Spitznagel, 1994). With higher rates of health issues older homeless women stand out amongst other homeless groups (Cohen, 1999; Grenier et al., 2013; North et al., 1994).

Even though a lot of attention goes toward homelessness and poverty prevention, consideration still needs to be given based on age and gender (Lewallen, 2013). As homeless women continue to age, their health issues become more prevalent compared to younger homeless populations.

Indicators for evolved services need to include disengagement and other factors related to challenges encountered with health system access. Many obstacles to health care access appear to be a major challenge for older homeless women. This vulnerable population has significant unmet health needs indicating multiple barriers to health system access (Baggett et al., 2013). Barriers include limited health coverage, medical specialist care needs, age-related health issues, and discounted issues directly associated with homelessness and older women (Brown, Thomas, Cutler, & Hinderlie, 2013; Bunolna, 2015; Vijayaraghavan et al., 2012). Homeless individuals have greater health service needs that many times burdened them with diseases that lead to acute and chronic health issues.

These diseases are many times influenced by socioeconomic deficiencies linked to age, gender, ethnicity, and social withdrawal (Ljoma, 2013). Aspects of illness and premature death among homeless individuals directly influence poverty, deficiencies in education, inadequate living environments, comorbidities of disease, mental disorders, and drug misuse (Bunolna, 2015). Sanitation, safety, overcrowded shelters, and system access issues for a full range of care are also linked to illnesses and premature death (Doran et al., 2013).

Health care providers and health system access are linked to health issues among older homeless women through social and economic dynamics that determine joint partnerships for better health (Ross et al., 2015). Discriminatory access to healthcare and treatment create a

domino effect that leads to trust issues, increased ED and hospital admits. The cost of health care along with mental and emotional walls create openings for discrimination. Additionally, poor delivery of care and worsened health outcomes are also directly associated with discrimination (Brown, Thomas, Cutler, & Hinderlie, 2013; Bunolna, 2015; Doran et al., 2014; Richard et al., 2016; Ross et al., 2015). The emphases on the growing health problems among older homeless women suggest a culmination of reasons for advancing disengagement.

The experiences and attitudes of older homeless women toward health care access can provide invaluable insights into challenges they face when dealing with misinformation and voids in understanding system access. Older homeless individuals suffering from various addictions and mental disorders have a higher likelihood of system access challenges (Grenier et al., 2013; Mott et al., 2012). Reliable models of care are key elements for promoting stable living arrangements and in assisting in the management of addictions and mental disorders (North & Smit, 1993; Oudshoorn et al., 2013; Thomas-Henkel, Hendricks, & Church, 2015).
Older homeless women who struggle with mental and physical health issues also encounter problems with health system access because of needed multiple levels of help and care from a medical specialist which in turn presents extreme challenges for medical providers (Maness, & Khan, 2014). Loss of memory is a major problem among older individuals especially the homeless (Grenier et al., 2013).

Other literature suggested that self-reporting among some with severe mental disorders and health problems are not necessarily key reasons homeless individuals do not access the health system (Tsai, Rosenheck, Culhane, & Artiga, 2013). Mental health challenges among

older homeless women further suggest that socially forced disengagement is an underlying problem that contributes to health and issues related to system access.

Overall life traumas among older homeless women contribute to events that activate poor health choices. These life traumas include emotional imbalances linked to early traumatic family life situations, furthering the need for additional research for the importance of specialized medical care for older homeless women (Grenier et al., 2013; Padgett, Smith, Henwood, & Tiderington, 2012). Also, other literature directly linked to ED visits suggested that childhood instabilities were related to homelessness, unstable health behavior, and depression (Mautner et al. 2013). Additional findings related to older homeless individuals indicated that ED visits and hospital admissions were directly related to periods of instability and stress that stemmed from a young age (Thomas-Henkel, Hendricks, & Church, 2015). Evidence of social withdrawal is replete with unhappy early periods of life as causative to unstable health choices and social dejection.

One main reason older homeless women are not appropriately accessing the health care system is due to the unstable housing directly linked to well-timed system access (Huynh, 2015; Kehn, Ho, & Troll, 2013; Argintaru et al., 2013; McNeil, Guirguis-Younger, & Dilley, 2013). Conversely, other authors indicated that personal health does not have direct links to housing status (Waldbrook, 2013). While, other findings suggested that possible perceived barriers and challenges such as unmet health needs, delays in treatment and other related issues. The health care system currently functions with hindrances to access for older homeless women (Brown et al., 2013; Waldbrook, 2013). Older homeless women are a minority and need open and reliable

access to preventative care, health screenings, and medical treatment to avert long-term illnesses (Vijayaraghavan et al., 2012).

Homeless individuals worldwide have varied, and complex health needs evidencing significant obstacles related to education limitations on ubiquitous diseases (Campbell, Neill, Gibson, & Thurston, 2015). Health care delivery needs to be specific and be based on older homeless women's related health needs and wants with stress-free assisted access (Chambers et al., 2013; Dhemba & Dhemba, 2015). Other barriers to system access for the homeless are due to non-gender suitability, geographic issues, short and temporary housing, as well as program restrictions (Hamilton, Poza, & Washington, 2012). Additionally, barriers for older homeless women to system access was directly associated with discrimination, fear of exam outcomes, and being uninformed about available medical services.

Barriers also include personal life issues and beliefs, breakdowns in communication, being rushed through exams and treatments, no attachments to support systems. Additionally, limited or no income, transportation issues, being shunned by medical staff, and no prescription benefits are culprits to barriers. Clinical barriers that happen between the patient and medical care providers were found to be major barriers (Campbell et al., 2015; Doran et al., 2013; Hamilton, Poza, & Washington, 2012; Hwang et al., 2013; Ljoma, 2013). On the contrary, other literature (Hasselman, 2013; Ljoma, 2013) indicated that health care workers currently provide assistance with enrollment, follow-up on appointments, offer education on treatment, and provide answers to questions, as well as, report on identified barriers and provide treatment goal counseling. Ample attention to a new identifier titled super-users categorize individuals with

complex needs based on physical health and social status and labels individuals as living below standard social levels. Strong points suggested that super users of the ED and admittance to the hospital found among the homeless lacked fulfillment of social support and timely medical care through the health care system (Hasselman, 2013; Brown et al., 2013; Mautner et al. 2013). Differences among homeless individuals based on prioritizing between healthcare and housing needs increased user lists. Participants included homeless individuals, mental illness cases, group care living persons, and some receiving personal care at home.

Superuser programs detect and identify subpopulations with high repeat visits to the ED and hospitals (Hasselman, 2013). Additional findings evidenced high rates of ED use among older homeless women (Brown et al., 2013), but without available data on hospitalization information and system access, with beliefs of high rates of sickness. ED visits among the homeless are 3% more than normal, and hospital admissions are 4% higher with longer hospital stays than general populations, even when low-income populations were considered the homeless exceeded their percentages for higher ED and hospital use (Brown, Thomas, Cutler, & Hinderlie, 2013). Limited accessibility to care included inconvenient locations, feelings of uneasiness, and paranoia. Legal surveillance controls and identity issues motivated being bounced around from one health facility to another. Also, related social stigmas were counted as accessibility challenges (Campbell, Neill, Gibson, & Thurston, 2015; Doran et al., 2013; Hasselman, 2013). Homeless individuals seem to prefer the ED over system access processing for preventative and primary care.

This overview of combined alternatives will assist policymakers and health care leaders first to separate and categorize the vulnerable population of homeless older women, then shift public and persuasive support to meet their changing health needs and wants. The examination of several studies helped further this research, for example, one study provided helpful solutions to explain delayed and nonuse of system access. By looking backward and pinpointing links to resilience with frailties that plague older homeless populations made a considerable contribution to existing information.

A model will be developed to show that age, gender, health system use, nutrition, and waning resilience are all connected to frailty and health issues. The research determined that frailty screening would be useful to guide medical providers and health agencies in creating health-promoting activities for older homeless individuals especially women (Grenier, et al., 2013; McInnes, Li, & Hogan, 2013; Salem et al., 2013). States in the U.S. differ in how they allocate funds based on health status and system use among homeless groups.

New developments in outreach and enrollment can be designed to target older homeless individuals to help them consistently access the health system as well as other health-related resources. States can expect cost reductions through the Medicaid expansion program which allows increased medical coverage and broadened system access (Tsai, Rosenheck, Culhane, & Artiga, 2013). Other studies suggested multiple factors that can contribute to emanating ideas for encouraging better health practices among older homeless adults.

For instance, providing services designed to be sensitive to treating health issues among older homeless women need to be focused on health and social determinants. Such services that

specifically critique for the health needs and social determinants for older homeless women can make a huge impact on this population (Campbell, Neill, Gibson, & Thurston, 2015). Open access can be updated to include health and environmental related services, safety assistance, cell phone availability, and computer training Serge & Gnaedinger, 2003). Hard-to-house individuals are considered, as well as those with mental challenges, addiction issues, and the aged.

Finally, Pathways to Housing was designed to focus on finding housing first while assisting with health-related issues specifically for those who are unstable in progressing through basic health programs. The Pathway to Housing approach also focuses on personal safety, improved long-term health outcomes, and effective socialization (McGhie, Barken, & Grenier, 2013). Education about the subject of system access among older homeless women advances the efforts of social change through the personal experiences, beliefs, attitudes, and perceptions of older homeless women.

Summary and Conclusion

Chapter 2 provides a clearer understanding of the challenges and difficulties faced by older homeless women. A generous review of literature considered with the inclusion of challenges with system access and unmet health needs. This study, along with various methodologies, other supporting studies, and related methods are all presented. Addressed in the literature review are evaluations and dissimilarities of viewpoints on research outcomes. Also included are a combined review of alternatives as possibilities for assisting policymakers and health care leaders in counting older homeless women as a vulnerable population. Needed are

separate considerations and categorization for specialized support to meet their changing health needs.

Chapter 3 presents and discusses the study design and methodology in detail. Also included in Chapter 3 are the specifics of my qualifications and role as a researcher, as it relates to data collection, analysis, criteria provided on selection of participants, ethical considerations, and participant safety and protection.

Chapter 3: Research Method

Introduction

The purpose of this phenomenological qualitative study was to gain an understanding of the thoughts, beliefs, and perspectives of older women toward access and use of health care services. Women considered were those who was either homeless, recently homeless, or at risk of becoming homeless. This qualitative study used a phenomenological approach to examine the lived personal experiences, beliefs, and attitudes of older homeless women toward health care access in Maricopa County Arizona. Another interest included perspectives on unmet health needs linked to access. I also explored the perspectives of older homeless women and what they perceived was needed to promote better health and increase health system access.

Research Design and Rational

RQ1: What are the beliefs and perspectives of older homeless women toward health care access?

RQ2: What do older homeless women believe are barriers to accessing health care?

RQ3: What do older homeless women perceive as enablers toward accessing health care?

RQ4: How do older homeless women perceive the personal use of health care services and links to their health?

Central concepts: perspectives toward health care access, perceived barriers to accessing health care, perceived enablers toward accessing health care, and perceptions of the personal use of health care services. Synonyms for search terms: identify barriers and remedies; identify enablers that make access possible; identify ways to diminish incorrect beliefs about the personal use of health care services.

Phenomenology theorizes that human recognition gives existence to everything that exists resulting from human ideas and paradigms (Cohen & Crabtree, 2006). Phenomenological psychology (objective) was chiefly developed by Edmund Husserl; while Alfred Schutz chiefly developed phenomenological sociology (subjective), (Smith, 2013). Schutz's (1967) objective was to define previously organized social world features that were considered significant and easy to recognize routines by average everyday people. The phenomenological tradition is one characteristic of several traditions which allows personal experiences, processes of knowing, viewing, and communicating to express or demonstrate how an individual understands the world (Cooren, 2012; Craig, 1999; Denzin & Lincoln, 1994; Latour, 2002). Traditions of phenomenological research involve participant observation and interviewing (Cohen & Crabtree, 2006). Perception is considered a phenomenon (Merleau-Ponty, 1964) which can link all the human senses together, such as taste, touch, sight, smell, and sound of an individual's experiences.

The research questions explore the perspectives and beliefs of older homeless women toward health care access, barriers to accessing health care, perceived enablers, and perceptions of health care services and personal health. Homelessness generates higher health risks and other barriers to health care than for the general population (Brown, Kiely, Bharel, & Mitchell, 2012; Waldbrook, 2013). Homeless women are among the fastest growing groups among homeless populations (Knopf-Amelung, 2013; Schaefer Solle, 2015). Specialized research is needed to determine their perspectives on access to timely medical care. Above all, older women are a sub-group among homeless populations that have not been given ample specificity to boost changes

related to health care system access (Maness & Khan, 2014). As the number of older homeless individuals increase with the aging of baby boomers, unique challenges for service providers will also increase the need for improving health care service accessibility to promote healthier lives. Although various programs exist that provide services for the homeless on national, state, and local levels, current studies exist that identify a lack of information. A needed focus is on the personal experiences, beliefs, and attitudes on health care access among older homeless women (Hall, 2010; Knopf-Amelung, 2013; Mautner et al., 2013; Waldbrook, 2013). For this study, the phenomenological approach was used to fill a gap in the research related to older homeless women's perspectives on the limited use of available health care and their perceptions related to seeking timely medical attention. The interview questions were designed to generate insights into the phenomenon of limited health care access among older homeless women, which can assist in creating new strategies to produce awareness for better health.

Role of the Researcher

In qualitative research data is facilitated through the researcher, making the role of the researcher that of a human instrument for data collection (Denzin & Lincoln, 2003). At this juncture, the researcher's overall role is to become transparent in all their dealings in the study. It is the researcher's responsibility to identify and understand the workings of a human instrument; such as how to describe their characteristics that are relevant to the study, their biases, assumptions, expectations, and experiences (Greenbank, 2003). Other researcher role responsibilities will include revealing any connected relationships on personal and professional levels and how these relationships managed during the study.

Additionally, the researcher needs to journal their reactions, reflections about their past, and bracketing implemented. The researcher's role is also emic because they will be in full participation of the phenomenon, but in situations where the researcher needs to be an objective observer (Punch, 2005); the researcher's role will switch to etic. Also, other areas of role responsibilities will include full disclosure of the location of the study and personal connections, conflict of interests, reasons for used incentives and strategies on how and issues will be addressed.

Qualitative Methodology

The study was based on descriptive research with a study sample of older women ranging from 45 years and above and classified as newly homeless, at risk of becoming homeless, or was homeless before the study. Newly homeless are women who have been homeless over a 12-month period. Older women who are at risk of becoming homeless would be those currently housed in various temporary places. Women who were homeless in the past are those who are currently in stabilized housing. The interview guide aligned with the interview questions based on exploring the general idea about health care access in a homeless situation; no predetermined list or order of questions used so that participants can speak freely about experiences, beliefs, and behaviors related to the research topic. The interview guide will have the name of the interviewer, interviewee, place of interview, time, and date of the interview, as well as interview questions and probes.

Qualitative research is based on purposeful efforts and seeks participants who provide the best information that answers the research questions and enhance understanding of the

phenomenon. Participant selection focuses on informal research questions, theoretical perspectives, and confirmations that will inform the study (Sargeant, 2012). Participants will be identified, contacted, recruited, and selected from homeless supported environments such as, public health facilities that work with homeless individuals, human services organizations that support homelessness, and homeless shelters. Format and context of the first interview are guided by a pre-defined list of issues to generate an informal conversation about health care access in a designated setting. Non-probable sampling for chosen participants is also important to the conditions of participant selection because it allows for snowball sampling. In the selection of the initial group of participants, assumptions made that they can refer to other potential participants who may fit the criterion and be interested in the study (Martínez-Mesa, González-Chica, Duquia, Bonamigo, & Bastos, 2016).

Interviews involved homeless women 45 years old and older; criterions based on characteristics related to age, gender, homelessness, and the lived experiences of the study phenomenon. Additionally, criterion sampling allows me to seek out those who closely match the conditions for my study throughout Maricopa County in Arizona. An unstructured approach used because the interview questions are not a pre-determined. The objective was to conduct informal interviews so that participants can guide the interview. Adequate time will be allowed for participants to review the consent form and other applicable documents. The time frame for interviews and check process will be up to 1.5 hours. There will be interview questions with the addition of probes. Interviews will be held at the location and facility named in the letter of cooperation. The ethical guidelines for informed consent will be followed based on respect,

beneficence, and justice for each participant and all others; to not cause any enticement of force, fraud, duress or pressure. Sufficient information will be presented in easy to understand language to help provide participants with an educated decision about participation in the study. Participant literacy capacities will be taken into consideration in the informed consent and interview information, also any questions answered about the consent form and throughout the interview process will be conducted on an 8th grade level or below.

The steps for informed consent for participants will be provided with study information via paper and verbally with ample time via a 30-minute check process to consider all options and ask questions. Extra care will be given participants to ensure they understand the study information. Assurance will be given to make sure all participation is voluntary. Ongoing information provided should anything change regarding the participant during the interviews. Each participant receives help as needed to understand the research topic and respond to each question on the consent form. Each participant will be provided with a signed and dated copy of the consent form. Assurances will be made that each participant follows consent form instructions - or make modifications as needed and notify the IRB of specifics. Assurances will be made of each participant signing the consent form before participating in the interview. The consent form language will be suitable for 8th grade level or below and all study materials will be kept separate from the consent forms. No personally identifying information will be collected except on the consent form which will allow the researcher to interview participants. Only anonymous code names will show in the research data, such as P1, P2, P3, etc. The researcher will also use a code sheet when transcribing the data and to communicate findings.

A report from the Arizona Department of Economic Security (AZDES, 2015) stated that Maricopa County's homeless population was 71% of the entire state's homeless population. Single men accounted for being the largest group of homeless individuals in the state with mention of families, women with children, and youth, but without mention of older women. The major cause for the absence of health care accessibility was due to the inability of homeless adults to handle multiple barriers. The report also noted that in 2015 a state point in time (PIT) count totaled 2,957 homeless revealing an 18% increase since 2014.

A phenomenological study will allow me to use criterion sampling and select participants who closely match the criteria for my study throughout Maricopa County. A snowball sampling strategy used because it allows for additional aid in locating and gathering needed information from crucial informants on connecting and accessing information from older homeless women. Purposeful sampling will be used to allow rigorous focus on older homeless women at homeless shelters in Maricopa County and help me obtain rich insights into their personal experiences, beliefs, and attitudes.

Various selection criterions will be on characteristics related to age, gender, and the phenomenon. All participants will be older homeless women who have experienced the phenomenon of limited health care access. Participant characteristics include the timeframe of homelessness, personal use and experiences with system access, perceived barriers, and health needs. Criterion determined by advice based on policies, specializations, and current literature (Mack, Woodsong, MacQueen, Guest, & Namely, 2005). Another qualifying criterion may include interview subgroups (Sargeant, 2012). Also, taken into consideration was that some of

the participants may be from a minority or ethnic group and have learning challenges, or physical disabilities (Kammerer, 2014). The above-mentioned vulnerable attributes are not part of the qualifying criteria.

The sample plan was for ten older homeless women. Interviewing continued until data saturation was met in Phoenix Arizona's Maricopa County, which encompasses a research area (RA) of 52 cities and towns. Maricopa County is the fourth largest County in the US. Purposeful sampling will allow specifics, such as aged individuals, life experiences, study sites, and other factors associated with the research topic. Focus on the study was specifically for older homeless women whose needs and experiences were dissimilar than other homeless individuals, such as men and females under the age of 44.

Hard to reach individuals are usually those that are considered underserved, vulnerable, and with other difficult to define characteristics. Recruiting strategies will be conducted at The JUSTA Center, 1001 W. Jefferson St., Phoenix, AZ 85007 as well as sought out referrals from facility leaders to increase recruitment. The snowball sampling recruitment strategy used will include facility leaders at the targeted area with adherence to eligibility criteria, and eligible participant approvals. The method of facility contact will be face-to-face site visits, as well as by phone and email as applicable.

Achieving saturation was yet another important factor for possibly using more than ten participants because saturation produces quality, quantity, completeness, and may require additional information to exhaust evidence of new themes. A small number of additional interviews performed if needed as a precaution to capture any new themes.

Instrumentation

The process for using the data collection instruments will involve face-to-face interviews, audio taping, document reviews, and on-site note taking. To gain an understanding of the phenomenon from the participant's point of view and answer research questions, measurement devices for data collection will include notebook documentation of interviews. Detailed field notes created after each visit with diagrams and accounts of routine happenings.

Other instruments will include a timer, interview guide, consent forms, documented scheduled breaks, topic list, and an unstructured interview protocol to highlight transparency, credibility, systematics, and reproducible protocols. Audio recordings will be obtained using a tape recorder for interview recall, as well as note-taking. Validity will be obtained through measurements of selected instruments to assess the descriptive research questions accurately. For instance, the main research questions and interview questions were evaluated against the anticipated results. Additionally, content validity approached through using familiar legitimate and credible sponsors for obtaining acceptance and entrance into the facility to help ensure projected outcomes.

Data collection efforts will take into account adjustments needed for participants who refuse to take part in the study by creating a welcome environment to grow relationships for maximizing participation. Participants will be made aware that they can back out of the study at any time, but any provided information before their decision to refuse additional information will be used per the signed consent form. Adequate sample size will help ensure ethical and time-worthiness as well as ethical principles based on respect for all potential participants. Other

procedures for recruitment and participation include, allowances for various impairments, informed consent assistance, confidentiality assurances, as well as, explanations of procedures for the study, available intervention alternatives, explained relevant risk factors, participants uncertainties, participant capability assessments, and disclosure of content information. Additionally, procedures for steps on minimizing risks, providing protection and welfare for participants and stakeholders based on facility risk and protection management guidelines. Participant privacy will also be assured based on location rules and regulations for the protection of facility clientele.

Data collection methods will consist of interviews with a non-directive approach to ensure instrument selections meet with the inclusion of information sources for interviews, documents and audiovisual materials, which will allow for probing, and adjustments for reading and comprehension levels.

Recording, reviewing and taking copious notes based on varying aspects of the study, diagrams such as data and visual displays will be used to illustrate and present details for organizing, abridging, implicating, summarizing, concluding, and data transformation. Content information will include investigator identities, research purpose, procedures, interview time frames, benefits and risks, confidentiality assurances, contact information, follow-up guidelines, concealed identities, and participation, refusal, and withdrawal statements.

Data was collected directly from participants because a descriptive phenomenology interview was the main data collection method in this qualitative research to achieve rigor and illustrate links between data collection and analysis. Data was collected by the researcher through face to

face contact, written and recorded participant experiences with approval from the institutional review board (IRB).

The frequency of data collection and analysis events will rely on data saturation through coding. Recorded data captured via audio, translations, transcriptions, and note-taking. Follow-up procedures and plans include verification of follow-through on interview guidelines during and after interviews, such as checks on an audio recorder, additional note taking during the interview process. The process of interviewing focuses on rigor and validity through review of all data collection methods, post-interview debriefing, such as the pros and cons, as well as reflections, explanations, and follow up with participants.

The cycle of data analysis will involve a phenomenological research design using various processes. The participants used as principal components of analysis; writing copious notes will be performed during and after tracking and while taping investigative insights, daily transcribe notes into short and simple complete statements for the interpretive process while making comparisons against original information. Transform the transcribed interview statements into a single drafted document. Considerations for any left-over questions, vague interpretations, and incomplete thoughts included in the draft. Also, follow-ups by contacting participants multiple times will be performed to fill in any gaps with detailed notes on unresolved uncertainties. The plan will also include analysis of issues associated with access and rapport, study location, objects, recording and storing information, and participant selections.

A deadline and a copy of the drafted document will be given back to participants for corrections. Findings will be disseminated by the researcher out of respect for participant's

health and psychological well-being. The researcher will only share outcomes and themes of findings (minus individual data or directly transcribed notes) with facility leaders. If participants don't return to review study results by the deadline, original results will be used it as-is. Timelines for the study will include; travel time, consent form review, signing and verification, scheduled interview times consisting of no more than one hour for one-on-ones, data downloads and file preparation, transcription, translation, coding, and time for editing and making miscellaneous corrections. The plan will include categorizations of each research question and identify specific responses from each participant. Procedures for coding based on both pre-set and open format with a constant comparison for consistency as well as, other procedures selected to recognize themes and codes.

A data accounting sheet will be created to display each research question to show checks and minuses of interviews and audio captures. The NVivo software tool will be used to manage, code, and analyze data. Data collected related to the participants lived experiences with the use of health care services linked with their health, negative barriers in accessing health care, and positive and negative enablers toward health care access. Finally, analytic induction will be used for discrepant and negative cases to prove rules in patterns.

Issues of Trustworthiness

Credibility involved the establishment of believability through purposeful sampling. Purposeful sampling directly influenced the selection of participant settings, cooperative partners, agreement letters, and other important factors; as well as, contribute prolonged field time, produce quality data, member checking, and validation (Creswell, 2003; Patton, 2002;

Ploeg, 1999; Shenton, 2004). Transferability evidenced through comparisons among readers based on research situations and methods. Variations in situations and methods will involve snowball, chain, and purposeful sampling, sample size, and saturation.

Dependability based on the quality of the analysis and presentation to ensure that findings of the research are repeatable and consistent. Support is through gaining access to data collected from various public health agencies, support from researchers, and obtaining entrance approvals (De Clerck, Willems, Timmerman, & Carling, 2011). Information from data based on evidence needed to build themes and audits (Creswell, 2003). Confirmability (Patton, 2002; Shenton, 2004), will involve audit trails to illustrate research findings, researcher bias, and reviews conducted during the data collection process.

The study conducted after approval from Walden University's institutional review board (IRB). Approval to recruit and facilitate interviews pursued by the researcher from cooperative partners such as human services organizations that support homelessness, and homeless shelters. All participants receive information and explanations related to study disclosures, potential risks, confidentiality limitations, time commitments, and informed consent documents. Also, considerations for participant literacy capacities before presenting the informed consent and study information. Contact information for me and the study chair will be provided verbally and in written form. Additionally, all study related paper and system generated documents are kept in privacy envelopes; audios and electronic devices such as computers, smartphones, and USBs are password protected and stored in a locked office in the researcher's home where access is not available to anyone else. The consent form and data collection procedures are written to be

anonymous to protect identities, such as P1, P2, P3, etc. No participants names are stored with the research data, and the consent forms are stored separately. A record created by the researcher is kept stating time, day, and how any USB, CDs, and recorded data was physically stored by the researcher. All paper records will be shredded and recycled after the 5-year required storage period. Any data stored on a computer hard drive will be erased using a commercial software application designed to remove all data from the storage device after 5 years by the researcher. Homeless populations are considered vulnerable participants by the IRB, which necessitated the assurance of all special considerations. Criterion required that all participants be mentally competent to complete the interview coherently. Older homeless women challenged with mild forms of mental illness, but capable of finishing the interview and considered mentally competent by facility leaders was allowed to participate in the study.

Various levels of mental illness measured enormously high among the wide spectrum of homeless individuals. Therefore, extra precautions among participants ensued (Hwang, Stergiopoulos, O'Campo, & Gozdzik, 2012; Padgett, Gulcur, & Tsemberis, 2006; Scott, 1993; Snow, Baker, Anderson, & Martin, 1986; Sullivan, Burnam, Koegel, & Hollenberg, 2000; Tsemberis, 2010). Findings will be disseminated by the researcher out of respect for participant's health and psychological well-being. The researcher will only share outcomes and themes of findings (minus individual data or directly transcribed notes) with facility leaders.

Summary

Chapter three illustrates the sequence of procedures that explain the research design and rationale, the researcher's role, methodology, issues of trustworthiness, ethical procedures, and

the data analysis plan in detail. The goal will be to conduct qualitative research to explore experiences and utilization of health care system access among older homeless women ranging from 45 years of age and above in Arizona's Maricopa County. Face to face interviews performed with ten older women classified as newly homeless, at risk of becoming homeless or were homeless before the study. A phenomenological approach will be used to gain an understanding of the lack of system access among older homeless women.

Andersen's theoretical behavioral model and disengagement theory guided the study. NVivo's comprehensive data analysis software will be used for coding, data analysis, and management to capture in-depth insights of the barriers to health system access. This information will be a resource for providers and advocates for older homeless women to advance knowledge and increase current efforts for support.

Chapter 4: Results

Introduction

The purpose of this study was to gain an understanding of the thoughts and perspectives of women toward health care access and use of health care services in Maricopa County Arizona. This study was specifically interested in the personal experiences, beliefs, and attitudes of older homeless women. I chose a phenomenological qualitative study because of my curiosity about their experiences, beliefs, and attitudes toward having health care access. In this study I used two theories, the behavioral model of health care services and disengagement. The behavioral model of health care services assumes opposing priorities with the utilization of health care services that lead to barriers for homeless individuals needing medical care. The disengagement theory

postulates withdrawal from society as a natural stage of life for older individuals. Other study interest included perspectives on unmet health needs linked to access and what they believed was needed to fill identified gaps in health services. This chapter includes the interview analysis that highlight areas focused on demographics, data collection, data analysis, evidence of trustworthiness, results, and an end of chapter summary.

Demographics

This study consisted of twelve participants, all of whom were women 45 years old or older. Twelve participants met the criteria for my study in Maricopa County Arizona. A total of twelve participants completed the study. Criterion sampling, non-probable sampling, and snowball sampling were used to meet the conditions of participant selection. For instance, criterion sampling allowed me to seek participants who closely matched the conditions for my study throughout Maricopa County in Arizona. Non-probable sampling was used because it was applicable to the conditions of a transient population. Snowball sampling was used because it allowed for potential participants from other facilities who may have an interest in the study and fit the criterion. Ten participants were expected to provide data saturation; however, this study reached saturation with five participants. This study includes an additional two participants to increase the evidence of trustworthiness of the study.

In the sample, participants are grouped based on age, marital status, have children, place of birth, education, prior living conditions before coming to current facility, i.e. were they with friend, family, had a job, or from another facility, and time in an unstable housing situation.

Participants were free to share demographic information at their discretion due to the sensitivity of their housing situations, which resulted in some yes and no responses without explanations. Participants were chosen by the facility leader based on the study criteria. Participants were asked to verify that they were 45 years old or older before signing the consent form; 3 shared their actual age while the other 9 said yes. Marital status was based on having ever been married or divorced; 4 participants said no and 8 said yes. As to whether participants had children; 2 said no, 6 said yes, 1 said yes (2 girls), 1 said yes (3), 1 said yes (1 daughter), and 1 said yes (2). Only 1 participant was from the state of Arizona. Three participants had college degrees, 3 had some college, 2 competed a GED, 1 had a high school diploma, and the other 3 had completed high school courses. Five participants had a job prior to coming to the current facility, 4 were from another facility, 1 lived with a friend prior to becoming homeless, and 2 responded no to the question. All participants time at the current facility were 1-week, 2-weeks, 6-weeks, 2, 4, and 10 months, months in general, recently, and 2 did not answer the question. The Arizona Department of Economic Security (AZDES, 2011) reported that the Maricopa County homeless population based on race was 68%, White, 22% Black, 5% Mixed Race, 4% Native American, and 1% all other races. These percentages included men, women, and children which motivated my reasons for not focusing on any one particular race or ethnicity. Table 1 displays a summary of the participant demographic information.

Table 1

Summary of Participant Demographics

Participants	AGE	MS	HC	POB	ED	FFJF	TUSH
P1	53	No	No	IL	Degree	Family	Mos
P2	Yes	Yes	Yes	TX	GED	Friend	2-Weeks
P3	Yes	No	Yes	MO	Degree	Job	1-Week
P4	Yes	No	Yes	AZ	HS	No	Recently
P5	Yes	No	No	Africa	Degree	Job	10-Mos
P6	57	Yes	Yes	MD	GED	Facility	?
P7	Yes	Yes	Yes	CA	College	No	2-Mos
P8	Yes	Yes	Yes	MO	HS	Facility	Mos
P8	Yes	Yes	Yes	CA	HS	Job	4-Mos
P10	60	Yes	Yes	OR	College	Job	?
P11	Yes	Yes	Yes	MN	Diploma	Job	6-Weeks
P12	Yes	Yes	Yes	CA	College	Facility	3-Mos

Note. P = participant. AGE = 45+. MS = marital status, married or divorced. HC = have children. POB = place of birth. ED = education. FFJF = from family, friend, job or other facility. TUSH = time in unstable housing. MOS = months.

Relevant Study Characteristics

After I was on site at the study facility and introductions were made by the facility director between me and the participants before each interview. Each interview began with the me reading through a script for participant interviews which took approximately 2 minutes minus any questions being asked about the study. I explained the consent form with added emphasis on the participant's voluntary withdrawal anytime during the study. Each participant was asked if she had any questions before signing the consent form and starting the interview. After the consent form was signed and questions answered, the interview began. I then explained the audio recorder, turned it on and placed it in open view on the desk with the participant's approval. Participants were also informed that notes would be taken. At the end of each interview I

thanked each participant for their time and help towards the study. This was the standard procedure before each interview. The actual interview times ranged from 35 minutes to an hour. During the first interview I discovered a need to make a slight change to the wording about health care access because the state of Arizona has a program called Arizona Health Care Cost Containment System (AHCCCS), which is a Medicaid program. I rephrased my wording to "having access to health care" and had to define having access as opposed to being on AHCCCS on several occasions.

Participants

During the participant interviews they were all very direct in their responses. When I used probes, I was reminded that a response had already been given, by the participant saying, "I already told you or you said that already". Even though some participants were chatty they all appeared to be on edge and in a hurry to get through the interview which included multiple breaks. All twelve participants responded to all the interview questions either directly or indirectly, i.e. with a wave of the hand, nod of the head, or grunting sounds such as, uh huh or uh uh, interpreted as meaning yes or no.

Participants 2, 4 through 12 all perceived access to health care services as being good, with the following comments; "thankful I have it", "good", "It is the best", "I love having it", "I think it's fair", "is a good thing", "it helps with medical", "I love it", "I like having health care access", "It's been a huge benefit for me", "having access is a godsend". Participants 1 and 3 commented, "it was good when I had it" and "I heard about it and waiting to sign up". When asked their perceptions about barriers to accessing health care services, responses were,

“communicate more”, “they only cover the basic minimal things”, not “listen to patients”, they need to “not limit income”, need for “dental” coverage, “sitting on phone all day”, need to provide “more information”, “the hardest part is the transportation”, “unpleasant experiences and harassment”, “no body returns your phone calls”, and “consider location of doctor’s office”. Questions related to perceptions about having access to health care all twelve participants indicated they did not have any problems. When probes were introduced related to enablers, responses included contacting Social Security office, contacting another clinic, contacting current facility, or contacting partner facility, calling their nurse, having freedom of choice, and finding their own doctor; indicating that help was available when needed. Responses to getting help for awareness of needed care were, Participant 2 said, “I did it online”, Participant 3 said, “go to a clinic”, Participant’s 4 and 9 said, “ER”, Participant’s 5 and 8 said, “call or go to DES”, Participant 6 said, “through Mercy Care, Participant 7 said, “partner facility”, Participant 10 said, “When I got here, I didn’t know anything yes it was word of mouth”, Participant 11 said, “I just go to the doctor”, and Participant 1 and 12 did not respond to the question.

I also developed seven demographic questions and five probes to help guide data collection among participants in the context of health care access.

Demographic Questions

1. Are you 45 years old or above?
2. Have you ever been married or divorced?
3. Do you have children?
4. Are you a native of Arizona?

5. Before coming to this facility did you have a job, or did you come from another facility?
6. What is your highest level of education?
7. How long have you been in an unstable housing situation?

Probes

1. Can you tell me more about?
2. Can you go back to?
3. Can you repeat what you just said about?
4. What did you mean?
5. Would you explain?

Data Collection

All twelve participants were recruited by facility leadership and personally signed consent forms in front of me to take part in the study at the study facility in Maricopa County Arizona. A copy of the consent form can be found in Appendix F. This study used criterion sampling, non-probable sampling, and snowball sampling methods with a non-directive approach to ensure instrument selections met with the inclusion of information sources for interviewing, documenting, and audio recording, which allowed for probing adjustments to reading and comprehension levels. A series of unstructured questions were created to not influence participant responses to interview questions. Interviews were audio recorded, with hand written notes, and transcribed by the researcher.

An informational flyer for recruitment of the study was given to a facility leader to be posted on their office board. A copy of the flyer can be found in Appendix C. A script for participant interviews was used to welcome participants, introduce me, invite questions, and share information about the study. A copy of the interview script can be found in Appendix D. To ensure the accuracy of a phenomenological data collection approach I focused on the commonality of lived experiences among twelve older homeless women through interviewing.

All the interviews were conducted separately face-to-face in the same private office space with conformable seating, a desk, and office equipment. All participants were English speaking even though one participant said she was born in North Africa. There was no evidence in appearance or dialogue that she was born outside of the United States. The time frame for each interview and the check process was up to 1.5 hours. Participants were invited to sit anywhere in the interview room they felt most comfortable. Seven participants chose to sit at the side of the desk next to me, 3 chose to sit across the desk from me, and 2 chose to sit with our chairs facing each other away from the desk. The audio recorder was always explained and placed in open view on the desk with the participant's approval. Participants were also informed that I would periodically jot down notes. Frequencies and duration of the data collection process varied. Data was collected and the process was completed from November 2nd to December 8th, 2018 with the interviews lasting anywhere from 35-minutes to over an hour after the interview script was read. Participants were given extra time if they needed a break to answer a phone, go to the restroom, or make sure they had not lost their place in line for available resources at the facility, among other things.

Variations in the data collection process that differs from chapter three. The interview guide did not list the names of each participant for privacy reasons. Some of the participants stated that they had been homeless off and on which qualified them for the study. Criteria requirements for the study was explained by the facility leader prior to being introduced me. A timer was not used nor scheduled breaks given because of multiple interruptions by participants being interviewed. There was not any document reviews or diagrams created because all interviews were conducted one-on-one, with me taking notes, and using an audio recorder. No copies of interview notes were handed out or repeated interviews conducted due to lack of interest and the rapid transient behavior of participants. Copies of signed consent forms were given to the facility director because the participants would leave at the end of the interview and disappear.

Data Analysis

A descriptive methodology was used based on participants words, terms, and behaviors. The NVivo software tool was not used in the management of coding and analyzing data. The process for the data analysis began with an inductive coding method. Efforts were focused on creating categories from the research questions. My next steps were to read my notes taken during each participant's interview; one at a time then listen to each recording while being attentive to codes and any emerging themes. After the transcripts were completed, I began the process of hand coding using a structured format to identify passages in the text through concepts and links between data and recurring words from each participant interview responses. With the transcribed data in hand, I again listened to the audio recordings for any additional

emotional and previously unnoticed responses. I continued to follow an organized process of coding by deciphering larger data groups of codes and splitting them into smaller inductive code groups. There were no unusual or discrepant circumstances encountered during the data collection process. All the transcripts were started or completed after each interview at the end of my day at the facility.

Checklist
1. Audio record demographics
2. Hand write demographics
3. Review hand written notes
4. Listen to audio recordings multiple times
5. Listen to audio recordings specifically for emotional content and unsusal responses
6. Document audio recordings
7. Analyze each interview with emphasis on recurring code words
8. Create categories associated with research and interview questions
9. Create codes by highlighting recurring words
10. Create themes by highlighting recurring phrases and words
11. Create and associate themes with research questions
12. Create themes associated with interview questions

The first level of preliminary codes were created after each interview to guide the development of categories and thematic themes. The process also involved creating new themes; matching codes, words, or phrases to theme headings before and after interviews. Multiple themes were identified from written, verbal, and recorded interview materials that either matched or were closely associated with the research questions. Emphasis were focused on investigating, examining, and documenting themes within the data to describe phenomenon connected to research questions.

Table 2

Categories Created from Research Questions

Research Question 1 What are the experiences, beliefs, and perspectives of older homeless women toward health care access?	Research Question 2 What do older homeless women perceive to be barriers in accessing health care?	Research Question 3 What do older homeless women perceive as enablers toward accessing health care?	Research Question 4 How do older homeless women perceive the personal use of health care services as linked toward their own health?
Feedback on first hand experiences with access to health care.	Barriers to health care services and unmet health needs	Support with health service access needs	Personal use compared with available health care services

Table 3

Emerging Themes Developed from Research Questions

Research Questions		Themes
1	What are the experiences, beliefs, and perspectives of older homeless women toward health care access?	Thankfulness Lack of problems Kindness Good doctors Beneficial Good relationships
2	What do older homeless women perceive to be barriers in accessing health care?	More is better Better services Increase communication
3	What do older homeless women perceive as enablers toward accessing health care?	Available resources Awareness
4	How do older homeless women perceive the personal use of health care services as linked toward their own health?	Know how Asking questions Build relationships

Evidence of Trustworthiness

Creditability

I visited the study site on one occasion prior to IRB approval to meet the facility leaders, tour the facility, get permission to conduct my study, and obtain a signed letter of cooperation by a facility director. Communication was maintained over a period of twelve-months through emails, phone calls, and cards, i.e. thank you and Christmas. Before the data collection stage began after IRB approval, I revisited the facility on 2 occasions prior to the study to discuss previous conversations about the purpose and importance of the study. I also inquired if anything had changed since my earlier visit regarding company policy and the study protocols Reassurance about confidentiality was emphasized to participants prior to each interview about audio recordings and notes that I would not be sharing any information with anyone.

Credibility involved the establishment of trustworthiness through multiple sampling methods, such as; criterion sampling, non-probable sampling, and snowball sampling to meet the conditions of participant selection. For instance, criterion sampling allowed me to seek participants who closely match the conditions for my study throughout Maricopa County in Arizona. Non-probable sampling was used because it was applicable to the conditions of a transient interview setting. Snowball sampling was used because it allowed for potential participants from other facilities who may have an interest in the study and fit the criterion. Purposeful sampling directly influenced the selection of participant settings because privacy was a key factor for confidentiality and conducting interviews. Prolonged interview time was allowed for each participant to produce quality data, member checking, and validation.

Transferability

Transferability was kept in mind to ensure that data demonstrated specific findings of the study that was applicable to comparable situations without losing original meanings and extrapolations. Transferability was also evidenced in the data through comparisons based on other research situations and methods. Variations in situations and methods from this study were also based on criterion, non-probable, snowball, and purposeful sampling; sample size and saturation. Additionally, quotations were used in the details and thick descriptions of participants responses that demonstrate the importance of the data, so readers can easily determine transferability.

Dependability

Dependability of the study was based on quality analysis and presentation to ensure that researched results were similar, repeatable, and consistent through using the same method during each participant interview. The study was conducted through access to data collected from one specific facility with the availability of similar partnering facilities. Dependability of collected data was based on evidence needed to build codes, themes and data audit techniques to repeat the process for similarity and consistency. Multiple sampling methods were used to support and allow for easy replication.

Confirmability

The confirmability process involved multiple audit trails to demonstrate researched findings, inspections, and verifications that would illustrate why, how, where, and when

decisions were reached, i.e. choices, approaches, and methods. Results of the study were specifically based on the experiences, attitudes, perceptions, and beliefs of the study participants.

Results

The purpose of this study was to investigate the personal experiences, beliefs, and attitudes of older homeless women toward health care access. The research questions explored their views and perspectives about access and use of health care services. Other interest included perspectives on unmet health needs linked to health care access. Participant interviews from this study led to categories, codes, and emerging themes from the data analysis in response to each research question and interview questions.

Table 4

Themes from Participant Responses

Research Q1	Research Q2	Research Q3	Research Q4
What are the experiences, beliefs, and perspectives of older homeless women toward health care access?	What do older homeless women perceive to be barriers in accessing health care?	What do older homeless women perceive as enablers toward accessing health care?	How do older homeless women perceive the personal use of health care services as linked toward their own health?
Sub-Questions	Sub-Questions	Sub-Questions	Sub-Questions
Interview Q1 What are your thoughts about health care access? Interview Q2 How do you personally seek health care? Interview Q3 What has been some of your experiences with seeking health care while in an unstable housing situation? Interview Q4 What do you think would encourage you to seek health care when you want to?	Interview Q1 What are some things that would keep you from seeking health care services? Interview Q2 What are your thoughts about seeking help if you were having problems getting health care? Interview Q3 How would you go about getting help to get the health care you need?	Interview Q1 What do you think would help make access to health care easier to get? Interview Q2 What are your thoughts about asking for help from people who work in health centers? Interview Q3 What has been your experience with asking for health information?	Interview Q1 What do you think about being able to find or access health care? Interview Q 2 What are your thoughts about health care workers' ability to help you? Interview Q 3 What are your thoughts about the health information you receive? Interview Q 4 What have been your experiences with contacting a health center after you've received health care services?
Themes	Themes	Themes	Themes
Thankfulness Lack of problems Kindness Good doctors Beneficial Good relationships	More is better Better services Increase communication	Available resources Awareness	Know how Asking questions Build relationships

Research Question 1

RQ1 addressed the experiences, perceptions, and beliefs of older homeless women toward having access to health care services. Interview questions along with probes were used to invite openness. Following a predetermined protocol use by the researcher, consisted of a participant interview guide, audio recorder, and note taking. After the fifth interview the researcher noticed a consensus between participant interviews, that having health care access was much needed and appreciated. Responses from all twelve participants were expressed positively about having access to health care services. Only one participant voiced disappointment over having lost her AHCCCS and believed she was no longer eligible to seek health care services until she learned during a break that she had only lost her AHCCCS card and just needed a replacement. The researcher was impressed with the level of understanding expressed by all the participants. All participants had taken upper level high school courses, had a GED, a college degree, or were Trade School Certified. The emerging sub-themes from the interview questions were based on perceptions of personal experiences and beliefs.

Emergent themes from participant pooled responses RQ 1: Participants 2, 4 through 12 all perceived access to health care services as being good, with the following comments; “thankful I have it”, “good”, “It is the best”, “I love having it”, “I think it’s fair”, “is a good thing”, “it helps with medical”, “I love it”, “I like having health care access”, “It’s been a huge benefit for me”, “having access is a godsend”. Participants 1 and 3 commented, “it was good when I had it” and “I heard about it and waiting to sign up”.

Research Question 2

RQ2 investigated participants' perceptions regarding barriers to healthcare access. Continuing the same protocol as with research question 1 and subsequent interview questions, the researcher used a participant interview guide, audio recorder, and wrote notes Interview questions and probes brought about some gestures of raised hands, dropped heads, and looks of hopefulness, as well as, verbal disappointments. Participants would go back to talking about the benefits of having health care AHCCCS which helped make life easier. When asked if the question was understood, the response was always in the affirmative. The participant that talked about unpleasant experiences and harassment identified an isolated experience that resulted in a good outcome i.e. she gained added help. The emerging sub-themes from the interview questions generated participant ideas on how to make AHCCCS better.

Emergent themes from participant pooled responses RQ 2: When asked their perceptions about barriers to accessing health care services, responses were, "communicate more", "they only cover the basic minimal things", not "listen to patients", they need to "not limit income", need for "dental" coverage, "sitting on phone all day", need to provide "more information", "the hardest part is the transportation", "unpleasant experience and harassment", "no body returns your phone calls", and "consider location of doctor's office".

Research Question 3

RQ3 investigated participants perceived enablers for accessing health care services. As with the other research questions and interview questions the researcher followed the same protocol using the interview guide, audio recordings, and note taking. All participants expressed

their awareness of what was available and how they used those resources. The emerging sub-themes from the interview questions were based on awareness and available resources.

Emergent themes from participant pooled responses RQ 3: Questions related to perceptions about having access to health care all twelve participants indicated they did not have any problems. When probes were introduced related to enablers; responses included identifying resources that would make having health care access better and naming abilities such as, contacting Social Security office, contacting another clinic, contacting current facility, or contacting partner facility, calling their nurse, having freedom of choice, and finding their own doctor. All participants said that help was available when needed.

Research Question 4

RQ4 explored participants perceptions on personal use of health care services as it relates to their own health. As with the other research questions and interview questions the researcher followed the same protocol using the interview guide, audio recordings, and note taking. The researcher noticed early in the study that participants were matter of fact about their responses. The indication was that they knew what was available and how to use it. One participant said that everyone was very helpful especially other homeless individuals that she'd met at the study facility and partnering facilities. The emerging sub-themes from the interview questions were based on building relationships, know how, asking questions.

Emergent themes from participant pooled responses RQ 4: Responses to getting help for awareness of needed care were, Participant 2 said, "I did it online", Participant 3 said, "go to a clinic", Participant's 4 and 9 said, "ER", Participant's 5 and 8 said, "call or go to DES",

Participant 6 said, “through Mercy Care, Participant 7 said, “partner facility”, Participant 10 said, “When I got here, I didn’t know anything yes it was word of mouth”, Participant 11 said, “I just go to the doctor”, and Participant 1 and 12 did not respond to the question.

Summary

Chapter 4 demonstrates an in-depth examination of data collection methods, data management, trustworthiness of the data, and data analysis. In this chapter, I explored study findings and evidence of trustworthiness throughout the research. I presented all twelve participant demographics, the coding process, categories, emerging and main themes for both research questions and interview questions identified in the data analysis. Study results were presented in chronological order of the four main research questions. Overall, thirty-four emerging and major themes were revealed from the participant interviews. Key comments made by participants were included with quotation marks to support each theme and the analysis of the meaning implied by the participants.

Major themes that emerged from the first research question in the data included, personal experiences, beliefs, feelings, what was heard, about having access to health care. There was an ongoing consensus of gratefulness among all twelve participants for access to health care services. Gratitude was expressed for provided transportation to medically related appointments even though there were some complaints about drivers showing up late. On more than one occasion participants shared that drivers went in with them to their appointment and explained to the desk clerk that it wasn’t the participants fault for being late. This same type of adoration was given on multiple occasions by the participants regarding services related to health care access.

Major themes generated from the second research question were based on transportation issues, long wait times, harassment, and not having a physical address. Many of the participants complained about the provided transportation being unreliable, but the drivers were good and caring. Encountering long wait times on the phones as well as at health care facilities were an ongoing concern among all participants. Harassment and discrimination was an isolated incident with one participant at an establishment that provided clothing. The biggest concern among many were being on a wait list for housing for both those with and without any income.

Major themes generated from the third research question from participant responses were interesting, because all participants said they did not have any problems, but all identified areas that would help make access to health care better such as, more communication, dental benefits, personal income, better transportation, affordable housing, and then they identified their personal abilities i.e. contacting Social Security office, contacting another clinic, contacting current facility, or a contacting partner facility, calling their nurse, having freedom of choice, and finding their own doctor. All participants said that help was available when needed. Finally, major themes generated from the fourth research question were based on; having good experiences, healthcare workers being very personable, the system being very accessible and easy to use, and lifesaving. Barriers identified in the second research question did not appear to be a major problem because participants spoke highly of people who had helped them and the benefits they were receiving from the current facility and partner facilities.

Findings suggested that access to health care services were mostly related to services provided by health care providers and workers, facility leaders, facility workers and volunteers,

drivers, etc. All participants reiterated that since becoming homeless many strangers were kind, showed them interest, and acknowledged their presence. In terms of the homeless culture, participants expressed that having health care access was vital to their health especially during the later stages of life. However, they also expressed beliefs that more could be done to better services i.e. wait times on the phone and at health facilities, more communication between medical staff and patients. Participants demonstrated beliefs about health care access being better for them if they were housed because housing and access to health care were spoken of interchangeably.

During the interview's participants talked about living on the streets, sleeping on benches, against buildings, in yards, out in the open, or anywhere they felt safe. Some participants mentioned that there were areas for homeless individuals to sleep that were policed during the night for their safety. Provisions mentioned by participants were, clothing which included shoes, pants, socks, stockings, hats, gloves, dresses, under-ware, blouses, and toiletries. The facility was operated by a facility director, other leaders, hired workers, and volunteers. There was an area with a greeter each time I visited the facility. Offices were in every area of the building and everyone's doors were open to facility attendees. There was a mutual gathering area for workers and attendees with many tables and chairs for various uses such as, for meal times, waiting for the computers, phones, or to meet with staff. Everyone observed was extremely kind and helpful to facility attendees and on many occasions expressed their love for the attendees and the work they performed. The facility was very orderly, clean, and organized. There was an open chapel for workers and attendees with a lot of available religious and other

self-help materials, for the taking. According to a facility worker donations to the facility were delivered on various days and times and stored in areas that were kept open during the day for easy access. There was a kitchen that served hot meals donated by various contributors and delivered to the facility twice a day for breakfast and lunch. According to a facility leader and several attendees' lockers were provided with combination locks for personal belongings. There was a schedule for daily showers and fresh clothing was made available to those who wanted a change of clothes. Computers and printers were available in open spaces as well as phones for private use. There was a good-sized library which was usually very busy with attendees during each of my visits.

Other services observed were drivers picking up attendees, workers providing specialized services i.e. for first time attendees, etc. According to a facility attendee methods of transportation provided by the facility included; taxicabs, uber drivers, and bus passes. When an attendee agreed to interview with me during breakfast or lunch time, the director or another leader would let the attendee know that they would gladly save a lunch or breakfast for them while they completed the interview, and each time I observed them handing securely covered food to my interviewee. Outdoors on the side of the building was a fenced in area where facility attendees congregated playing games, talked on cell phones, ate food, etc. Workers and facility attendees were very nice and respectful towards each other. Other mentions included; access to computers were for job searches, phones were made available to make medical or job-related appointments, transportation was for doctors' appointments and urgent care services. Other services provided included help with housing, temporary addresses to receive benefits i.e. social

security, and other government services, etc. Every participant expressed gratitude for facility leaders and workers and the help they received each time since first visiting the facility.

There were no adverse situational findings in this study. On one occasion in response to the first interview question a participant said having health care access "was good when I had it" and expressed that she had lost her AHCCCS and believed she was no longer eligible to seek health care services, until she learned during a break that she had only lost her AHCCCS card and just needed a replacement.

This study revealed the experiences, attitudes, and beliefs of older homeless women ranging from 45 years and above, classified as newly homeless, at risk of becoming homeless, or was homeless before the study. Newly homeless were women who had been homeless over a 12-month period, those who were at risk of becoming homeless, and those who were currently housed in various temporary settings, as well as, any who were homeless in the past but currently living in stabilized housing. Considering that the study participants were all high school, GED, Trade School certificate holders, or had college degrees evidenced a need for new knowledge regarding homelessness among a new class of survivors. New health information and survival techniques among this class of individuals may help health care providers as well as public health improve health promotion and education to motivate better health related services among older homeless populations.

In Chapter 5, gives an interpretation of findings, focused on confirmations, disconfirmations, or extensions of knowledge on disciplines by displaying comparisons with what was found in the peer-reviewed literature described in chapter 2. Additionally, I provided

an interpretation of applicable contextual findings related to the theoretical framework of the Behavioral Model of Health Care Services and Disengagement Theory. Chapter 5 also included limitations of the study, recommendations, implications, and a conclusion.

Chapter 5: Summary, Conclusions, and Recommendations

Introduction

The purpose of this study was conducted to gain an understanding of the thoughts and perspectives of homeless older women toward health care access and use of health care services in Maricopa County Arizona. This study was specifically interested in their personal experiences, beliefs, and attitudes. Researchers have shown that the wide-range of homeless populations generate higher health risks and other barriers to health care than the general population (Brown, Kiely, Bharel, & Mitchell, 2012; Waldbrook, 2013). Currently, women are one of the fastest growing groups among homeless populations (Knopf-Amelung, 2013; Schaefer Solle, 2015). Literature proposed that homelessness presents added challenges for adults in need of timely medical care and that often-homeless individuals will delay seeking medical attention until health issues reach emergency care levels (Donovan et al., 2010; Huynh, 2015). Research proposes that many older homeless women are not accessing the health care system promptly, the death risk becomes higher than it does for the general population of aged women (Donovan et al., 2010). Among homeless women health issues and problems accessing basic care among older populations is a growing problem (Waldoch, 2013). Older homeless women faced with increased health issues, multiple challenges related to accessing basic care, and low incomes which put them at higher risk of becoming homeless and delaying medical treatment are on the

rise (Waldbrook, 2013; Waldoch, 2013). Additionally, repetitive users of the emergency department and hospital stays were mostly found among the homeless who lacked fulfillment of social support and timely medical care through the health care system (Brown et al., 2013; Hasselman, 2013; Mautner et al.,2013).

I chose a phenomenological qualitative study because of a curiosity about older homeless women's experiences, beliefs, and attitudes toward having health care access. In this study I used two theories, the behavioral model of health care services and disengagement. The behavioral model of health care services assumes opposing priorities with the utilization of health care services that lead to barriers for homeless individuals needing medical care. The disengagement theory postulates withdrawal from society as a natural stage of life for older individuals. Other study interest included perspectives on unmet health needs linked to access and what study participants believed was needed. This chapter includes the interview analysis that highlight areas focused on demographics, data collection, data analysis, evidence of trustworthiness, results, and an end of chapter summary.

Fourteen central themes emerged from participants responses to the interview questions and probes i.e. (a) Thankfulness, (b) Lack of problems, (c) Kindness**,** (d) Good doctors, (e) Beneficial, (f) Good relationships, (g) More is better**,** (h) Better services, (i) Increase communication, (j) Available resources, (k) Awareness, (l) Know how, (m) Asking questions and (n) Build relationships. I used multiple sampling methods as demonstrated in chapter 3; based on criterion, non-probable, snowball, and purposeful sampling; to ensure sample size and saturation. Twelve women 45 years old or older who visited the same study facility participated

in the study. All participants in the study were asked questions from a semi-structured interview guide with applicable probes, which included seven demographic questions. I also used an audio recorder and took notes. I asked each participant questions about their personal experiences with having health care access, perceived barriers, enablers, and about their personal use of health care services as linked to their own health. All participants spoke openly about personal and social factors in the context of health care access.

In this chapter I discuss my interpretation of findings, focused on what I discovered in the researched literature described in chapter 2. Additionally, I provide an interpretation of applicable contextual findings related to the theoretical framework of the Behavioral Model of Health Care Services and the Disengagement Theory. I also discuss limitations of the study, implications, and offer my recommendations and end this chapter with my conclusion to the study.

Interpretation of the Findings

The data analysis of the study demonstrated that social perceptions of older women in the context of health care access among homeless women in this study had a positive impact on their well-being. Related themes were supported by Donovan et al., (2010) and Oudshoorn, et al. (2013). Participants beliefs were communicated in perceptions of survival capabilities. Evidence of trustworthiness was demonstrated in the interview results provided by each participant. Participants communicated their experiences, beliefs, and attitudes regarding health care access i.e. medical care, customer service, health information, etc.

I did not find that having access to health care services was difficult or challenging based on the responses to the interview questions. There were 14 themes that generated answers from the 4-research questions. What are the experiences, beliefs, and perspectives of older homeless women toward health care access? What do older homeless women perceive to be barriers in accessing health care? What do older homeless women perceive as enablers toward accessing health care? How do older homeless women perceive the personal use of health care services as linked toward their own health? Multiple links were discovered between each research question and themes evidencing mutual experiences and beliefs. There was a seamless train of thought that manifested in the participants perceptions further linking each research question to applicable themes.

I found that all twelve participants perceived their personal experiences with having access to health care services as positive. Barriers to having access were perceived as tolerable. Participants had a keen awareness of enablers and shared perceived ideas on how to make access to health care services better. As far as their own personal use of health care services as linked to their own health, perceived capabilities were communicated. Additionally, a unique sense of community existed and there was no blaming or evidence of hopelessness. There was no mention or indication given that family support was available or open for discussion; due to the way each participant hurried past the demographic questions about marriage and children. Out of the twelve participants two mentioned religion during the interviews, one said having access to health care was a "godsend" and the other said, "the bible says you gotta be thankful". At the

end of each interview all but one participant after shaking my hand hugged me before saying goodbye.

Research Question 1

Available Access

Very little data collected corresponded with previous research discussed in chapter 2. Findings in this study evidenced many influential factors that support unrestricted access to care. The first research question and six applicable themes were re-joined in unified positive experiences. The participants in this study, expressed their appreciation multiple times for having access to health care during homeless periods in their lives. When asked about their personal experiences many responded by sharing stories and how they were very pleased with providers, health care workers, and medical services rendered. Each participant was very engaging, and several said they were glad to tell their story. However, a couple of participants said the services available were limited, referring to the AHCCCS program. Another experience alluded to the change of doctors because of how the AHCCCS program works with provider services. All 6 themes are mutually cohesive toward appreciation for being able to freely access health care services from the multiple available avenues i.e. urgent care facilities, doctor's offices, emergency departments, and hospitals. A confirmation of finding from researched literature from chapter 2 noted that, across the spectrum of homelessness, homeless individuals experience higher burdens of health issues above those with reliable homesteads and private health insurance (Argintaru et al., 2013; McNeil, Guirguis-Younger, & Dilley, 2013). However, at no time did any of the twelve participants identify any notable problems when accessing health

services, which led to several disconfirmations that would identify bad experiences (Argintaru et al., 2013; Brown, Thomas, Cutler, & Hinderlie, 2013; Kushel, 2012). Also contributing to disconfirmation of findings was that health care providers and health system access are linked to health issues among older homeless women through social and economic dynamics that determine joint partnerships for better health (Ross et al., 2015). Collected data in this study suggested that these are separate entities that together can be a strong support system in educating homeless populations about available resources.

Analyzation and interpretation of findings in the context of the Behavioral Model of Health Care Services theoretical framework. This framework was used for several reasons i.e. (a) Andersen's behavioral model is the most current development for health care access, (b) widely recognized and used for health care system utilization (Gelberg et al., 2002; Huey, Broll, Hryniewicz, & Fthenos, 2014; Ljoma, 2013; Lewis, Andersen, & Gelberg, 2003; Willis, Glaser, & Price, 2010), (c) the concept of barriers and enablers that apply to older homeless women's non-use and use of the health care system in Maricopa County in Arizona was applicable, (d) has been used extensively and is specific for vulnerable populations, (e) and used for gaining an understanding, explaining access to health care services, and physician care (Babitsch, Gohl, & von Lengerke, 2012; Derose, Gresenz, & Ringel, 2011; Heider et al., 2014). Additional confirmation of findings based on the Behavioral Model of Health Care Services theoretical framework proposes that homeless women with preexisting and current illnesses are at higher risk of acute and chronic diseases.

Analyzation and interpretation of findings in the context of the Disengagement Theory framework. This theory model was used because of it's growing recognition and has expanded over the years as well as, add richness to this study. Also because of its use in research to identify and describe social withdrawal among older individuals, which considered by Cumming and Henry as a normal stage of aging (Adams, 2000; Bungay, 2016; Crossman, 2016; Cumming & Henry, 1961; Gladis, 2014; Lewallen, 2013; McKenna, 2002; Somers, 1977; Tallmer & Kutner, 1969). Interestingly, the concept of disengagement theory presented nine postulates identifying the inevitable process of withdrawal from society and personal relationships (Crossman, 2016; Lewallen, 2013). Cumming and Henry (1961) suggested that close personal and communal withdrawals are a naturally emotional preprogrammed phenomenon that is part of the life cycle of older individuals but did not address or account for older individuals with unusual circumstances related to homelessness and health challenges.

A disconfirmation of findings revealed that withdrawal from society is not neccassarily a natural stage of life for older homeless individuals. However, there may be some truth to this theory as it relates to other environments with larger populations of older individuals or if its reference is to older individuals past the age of seventy-five. Each day while collecting data I observed facility attendees being quite cordial with each other. Several study participants stated that they were helped by other homeless individuals i.e. sharing how to survive, what resources were available, how to use resources, giving each other directions, when away from the facility watching each others belongings while using the restroom, etc. Other shared expereinces were about getting help and advice from local law enforcements and others.

Extended knowledge of findings related to the Behavioral Model of Health Care Services are applicable to concepts of the model attributed to the combined predisposing and enabling factors assesing opportunities for care and barriers to care that lead to behavior changes for both the care provider and the patient (McDonald et al., 2007). In this study participants shared a desire for strong relationships between themselves and care providers, especially those providers who were switched often because of the AHCCCS program. Other attributes of the behavioral model are the concepts that focus on the inclusion of equity, effectiveness, significance, physical health, and well-being, as well as predisposing, enabling, and needs that address both health and shelter needs (Derose, Gresenz, & Ringel, 2011; Maslow, 1943). Even though participants expressed immense gratitude for kind treatment and services when accessing health care services, they also shared perceptions on how their lives could be better if the system was enhanced to include minor changes. In many cases, the Andersen–Newman behavioral model of health services is viewed from a theoretical foundation to gain a better understanding of trust factors of older individuals and those in positions of authority who control various resources (Petrovic & Blank, 2015). Findings suggest that participants would rather have a nice comfortable place to call home, but while waiting for that to happen life on the streets, i.e. unstable housing situations, shelters, etc., can be tolerable with added conveniences related to health care access. The trust factor between individuals and various types of care providers and attendants can influence progression or regression toward the timely and convenient use of system access. To date no other framework adequately theorizes or deliberates on how years of

research and expertise of public health can impact health care access and address the needs of older homeless populations.

Research Question 2

Tolerable Barriers

Three major themes emerged from the collected data that corresponded with perceived barriers among study participants. There appeared to be a unified sense of inner strength and maturity when asked about barriers. All twelve participants spoke about uninhibited freedoms when using health care access. Confirmations of findings included agreement that, limited or no income, transportation issues, perceptions of occasionally being shunned by medical staff, and no prescription benefits were culprits to perceived barriers. Findings suggested that health care delivery needs to be specific and be based on older homeless women's related health needs and wants with stress-free assisted access (Chambers et al., 2013; Dhemba & Dhemba, 2015). Findings further suggested that these barriers could be alleviated via an added service provided by health care environments that would not necessarily be known to patients. Other barriers to system access for the homeless are due to non-gender suitability, geographic issues, short and temporary housing, as well as program restrictions (Hamilton, Poza, & Washington, 2012). These barriers did not materialize during the interviews, possibly because of the semi-structure of the interview questions. There was never any vocalized or observed mannerisms indicating fear, being misinformed, or mistreated in the context of health care access. Instead, participants spoke of having many experiences with hospitals, doctors, nurses, and other health care workers and how their performances of care was highly appreciated and respected. One participant said,

"the bible says you gotta be flexible, you gotta be thankful for all things". Another confirmation included barriers to breakdowns in communication and being rushed through exams and treatments. Participants expressed that more communication was needed between themselves and health care workers in general; only three participants spoke about isolated incidences. Participants expressed barriers regarding office visits to medical facilities were always good except on occasion there would be a perceived need for better services i.e. dental, income, hearing aids, vision care, etc.

Several disconfirmations were discovered; clinical barriers that happen between the patient and medical care providers were found to be major barriers (Campbell et al., 2015; Doran et al., 2013; Hamilton, Poza, & Washington, 2012; Hwang et al., 2013; Ljoma, 2013). The health care system currently functions with hindrances to access for older homeless women (Brown et al., 2013; Waldbrook, 2013). All twelve participants were specific in expressing gratitude for health care services rendered and did not express identified barriers as major problems. Another disconfirmation found in research was that this vulnerable population has significant unmet health needs indicating multiple barriers to health system access (Baggett et al., 2013). Additionally, several researchers found barriers related to limited health coverage, medical specialist care needs, age-related health issues, and discounted issues directly associated with homelessness and older women (Brown, Thomas, Cutler, & Hinderlie, 2013; Bunolna, 2015; Vijayaraghavan et al., 2012). In this study these specific barriers were not expressed by participants or sensed by me to the degree found in previous research. However, several of the participants spoke about ongoing health issues that needed special medical attention. Such as,

vision, hearing, and dental care, physical therapy, dermatology issues, etc., as well as, aches and pains not uncommon to other age groups. Lastly, prior research suggested poor delivery of care and worsened health outcomes are also directly associated with discrimination (Brown, Thomas, Cutler, & Hinderlie, 2013; Bunolna, 2015; Doran et al., 2014; Richard et al., 2016; Ross et al., 2015). Even though one participant spoke about harassment and discrimination; the experience was related to an isolated incident with an establishment that provided clothing. Another participant expressed gratitude for various similar facilities that cater to the homeless by making health care related appointments and providing transportation for them.

The major findings that support my collected data were that some researched literature indicated that health care workers provide assistance with enrollment, follow-up on appointments, offer education on treatment, and provide answers to questions, as well as, report on identified barriers and provide treatment goal counseling (Hasselman, 2013; Ljoma, 2013). All twelve participants emphasized that because current facility leaders, workers, volunteers as well as partner facilities treated them like they mattered and with notable respect that they would continue to frequent those facilities and want to live in proximity of these facilities because they work together to benefit older homeless individuals.

Extended knowledge of findings from research; even though a disconfirmation suggested that a main reason older homeless women are not appropriately accessing the health care system is due to the unstable housing directly linked to well-timed system access (Huynh, 2015; Kehn, Ho, & Troll, 2013; Argintaru et al., 2013; McNeil, Guirguis-Younger, & Dilley, 2013). Conversely, another author indicated that personal health does not have direct links to housing

status (Waldbrook, 2013). While, other findings suggested that possible perceived barriers and challenges such as unmet health needs, delays in treatment and other related issues; it was evident that because the study participants had experienced various life challenges over the years that being homeless was not a shocking experience, but one that was the result of choices made over the years that led to current social situations. All participants who spoke about working a job, did so with expressions of longing. For instance, one participant expressed disappointment in not being able to physically work anymore, something that she assumed she would be able to do well into her old age. Many expressed experiences similar to this as if to say the inevitable finally happened because of their own choices. At no time did any of the participants blame others for their situations but did express that they wished they had planned better or known that they would end up where they were.

Analyzation and interpretation of findings suggested by research that while women have even higher burdens of health-related challenges, such as those specifically unique to women and aging older women experience homelessness at a later age than men, especially when faced with lower incomes (Ellison, 2013; Waldbrook, 2013). Currently, the behavioral model is used to examine predisposing, enabling, and need factors in vulnerable populations. However, these factors were not determined during or after the data collection in this study. Literature and research analysis based on the theory of the behavioral model of health care services include previous studies indicating opposing priorities with the utilization of health services leading to barriers for homeless individuals needing medical care. These barriers showed confirmation and disconfirmation among study participants (Andersen, 1995; Gelberg, Andersen, & Leake, 2000;

Gelberg, Gallagher, Andersen, & Koegel, 1997; Lewis, Andersen, & Gelberg, 2003). The behavioral model of health care services proposes that homeless women with preexisting and current illnesses are at higher risk of acute and chronic diseases. These chronic diseases can result in death. Previous research also revealed that vulnerable populations currently ranked high within the health care access pool and use the ED more often than primary care services (Behr & Diaz, 2016; Huey, Broll, Hryniewicz, & Fthenos, 2014; Vijayaraghavan et al., 2012). As well as, that the roles of predisposing, enabling, and need factors can be evaluated and connected with frequent ED use (Behr & Diaz, 2016). Preexisting, current major illnesses, or treatments were not expressed by any of the participants in this study. Although some participants commented on having visited urgent care facilities, doctor's offices, emergency departments, and hospitals, noting was expressed about the frequency, content of visits, or types of illnesses.

Research Question 3

Improvable Enablers

The third research question generated two major themes highlighting perceptions on participant awareness and the available resources in the context of health care access. A confirmation of finding from research revealed that health care workers provide assistance with enrollment, follow-up on appointments, offer education on treatment, and provide answers to questions, as well as, report on identified barriers and provide treatment goal counseling (Hasselman, 2013; Ljoma, 2013). A disconfirmation of findings suggested that overall life traumas among older homeless women contributed to events that activate poor health choices. These life traumas include emotional imbalances linked to early traumatic family life situations,

furthering the need for additional research for the importance of specialized medical care for older homeless women (Grenier et al., 2013; Padgett, Smith, Henwood, & Tiderington, 2012). What was found among the participants in this study was that many spoke confidently about how they needed to take better care of themselves while in their current situations to preserve good health and maintain themselves by eating healthy as often as possible. Some expressed gratitude for free showers and clean clothing provided by the current and partnering facilites. One participant spoke about how sometimes the food provided was not the healthiest so she would pick and choose. The majority spoke about the importance of their skin, hair and overall appearance. Research noted that evidence of social withdrawal is replete with unhappy early periods of life as causative to unstable health choices and social dejection (Mautner et al. 2013; Thomas-Henkel, Hendricks, & Church, 2015). Participants in this study expressed a keen awareness of personally perceived ideas on how to make access to health care services better in the context of their own personal use of health care services. At no time did any participants in this study share experiences or perceptions linked between unhappiness and social dejection from early years of life.

Extended knowledge of findings from research suggested that homeless individuals worldwide have varied, and complex health needs evidencing significant obstacles related to education limitations on ubiquitous diseases (Campbell, Neill, Gibson, & Thurston, 2015). Results of this study found that because all participants were quite knowledgeable about health challenges i.e. diseases, symptoms', treatments, and cures. Most had cell phones and were computer literate. Some participants used words and phrases like research, analyzed, reviewed,

accessed sites on the internet, and so on. Research suggested that some homeless individuals manage to find various levels of suitable but temporary accommodations which make them appear risk-free and out of the loop among the sheltered and street homeless (Grenier et al., 2013; Mott, Moore, & Rothwell, 2012). Another area related to extended knowledge was a major observation based on how well some facility attendees were nicely dressed and articulate. All twelve study participants wanted me to know they were intelligent, knowledgeable, and quite capable. During one of my visits the facility director shared that twice a doctor from a medical facility visited the homeless resource facility because they did not believe that their patients were homeless when told that over the phone.

Analyzation and interpretation of findings in the context of the Behavioral Model of Health Care Services theoretical framework. Predisposing, enabling, and need factors can be structured based on an individual sense of belief and experience to reveal equity and inequity in health care system access (Hoebel, Starker, Jordan, Richter, & Lampert, 2014). This is one of the many benefits of the Behavioral Model of Health Services. Superuser programs detect and identify subpopulations with high repeat visits to the ED and hospitals (Hasselman, 2013). Based on the shared experiences and perceptions of the study participants, all expressed that they kept doctors' appointments and made sure they rescheduled if something happened that they could not be at their appointment on time. At no time did any participants express or indicate that they took for granted having the freedom to access health care services.

Analyzation and interpretation of findings in the context of the Disengagement Theory framework. Known sociologists such as Hendricks, 1994; Hochschild, 1975; Hooyman & Kiyak,

2011; Maddox, Jr, 1964; Parsons, 1966; Williams & Wirths, 1965; suggested that because society projects inequality to rights and resources, disengagement among the aged is not a personally chosen behavior. In this study participants as well as other facility attendees appeared to be deliberately polite and respectful of each other's presence and belongings, possibly because of the impermanent environment.

Research Question 4

Personal Capabilities and Awareness

The last research question generated three themes that helped describe participants expressed links to their education, knowledge, capabilities, and independence toward knowing what, where, and how to get needed medical help. The major finding validated expressions of appreciation for being able to freely access health care services from the multiple available avenues. i.e. urgent care facilities, doctor's offices, emergency departments, and hospitals. A confirmation of findings suggested that older homeless women are a minority and need open and reliable access to preventative care, health screenings, and medical treatment to avert long-term illnesses (Vijayaraghavan et al., 2012). Because of the internet and other means of access to health care information and the keen awareness of personal health needs the participants in this study evidenced this confirmation.

Both disconfirmation and confirmation of findings from research included aspects of illness and premature death among homeless individuals directly influence poverty, deficiencies in education, inadequate living environments, comorbidities of disease, mental disorders, and drug misuse (Bunolna, 2015). Sanitation, safety, overcrowded shelters, and system access issues

for a full range of care were also linked to illnesses and premature death (Doran et al., 2013). While these findings may be true in some environments inhabited by older homeless women; these extreme and dire situations were not evidenced in the shared expressions of the participants in this study.

Extended knowledge of findings from research regarding limited accessibility, being bounced around from one health facility to another, uneasiness, and paranoia (Campbell, Neill, Gibson, & Thurston, 2015; Doran et al., 2013; Hasselman, 2013). No expressions were shared regarding limited accessibility. However, a couple of participants expressed that available services were limited, referring to the AHCCCS program. Another participant expressed that she did not like seeing different doctors when she went in for her appointments. None of the participants spoke about having to go to multiple health facilities. Uneasiness and paranoia was expressed on the contrary, as looking forward to keeping appointments and receiving medical attention.

Analyzation and interpretation of findings in the context of the Behavioral Model of Health Care Services theoretical framework; as related to the forth research question and generated themes was supported because of the extension that included evaluated and perceived health status with the added element of public health prevention focused on individuals and access processes with emphasis on health outcomes and the gradation of health changes (Newhouse, 1993). The context of the Disengagement Theory framework were many times influenced by socioeconomic deficiencies linked to age, gender, ethnicity, and social withdrawal (Ljoma, 2013). Related factors were fragmented in part, because the focus was not specifically

on education, income, and occupation; but on perceived personal use of health care services as linked to their own health.

Limitations of the Study

This study consisted of twelve participants; all of whom were homeless and 45 years old or older which does not realistically represent all older homeless women in Maricopa County Arizona and especially not the state of Arizona. First, several limitations were proposed because women were one of the fastest growing groups among homeless populations (Knopf-Amelung, 2013; Schaefer Solle, 2015); which suggest changing dynamics in need of research on a larger scale. The homeless population continues to age and increase (Brown, Thomas, Cutler, & Hinderlie, 2013; Knopf-Amelung, 2013; National Alliance to End Homelessness**,** 2015); further evidencing limitations to the current study. Second, limitations were applicable to sample size and recall biases based on the homeless facility for this study experiencing high degree of transient facility attendees. The chosen sampling methods allowed for convenient sources for locating participants. There was potential for obscurity during reporting and succinctly characterizing interpretations and observations which added the potential for limitations. Another limitation included the unknown degree of mental and emotional challenges experienced by participants. Lastly, the physical presence of the researcher may have caused feelings of envy or resentment which may have influenced expressions of awareness, capabilities, as well as limited disclosures in the context of health care access.

Recommendations

Even though a lot of attention goes toward homelessness and poverty prevention, consideration still needs to be given based on age and gender (Lewallen, 2013). As homeless women continue to age, their health issues become more prevalent compared to younger homeless populations. Four recommendations were generated from the strengths, limitations, and literature reviewed in chapter 2. Overall findings evidenced multiple gaps in knowledge between the new homeless, chronic homeless, and age before disengagement. The first recommendation is for additional research on the new homeless maintenance of healthy habits and survival techniques. The second recommendation coincides with Vijayaraghavan et al., (2012) older homeless women were a minority and need open and reliable access to preventative care to avert long-term illnesses; this can help older homeless women gain and maintain levels of social respect, increase motivation for healthy lifestyles, and provide a strong support system via existing health-related resources and support facilities.

The third recommendation proposes greater efforts be made between health care decision makers and public health for patient information related to health care access, health needs, and homelessness on community, state, and national levels to guide medical decisions and treatment. This information can help provide a better understanding of the growing demands for older homeless populations which is projected to double by 2050, generating over an 89 million populace of older homeless individuals with a 33% increase in homelessness by 2020 which averages out to approximately 95,000 homeless (Knopf-Amelung, 2013; (Dhemba & Dhemba, 2015). A culture supported through collaborations by both health care and public health leaders

can better serve older homeless populations. For instance, such services that specifically critique for the health needs and social determinants for older homeless women can make a huge impact on health (Campbell et al., 2015). Open access can be changed to include safety assistance, health education, and encourage better health practices; which were mentioned by many of the participants in this study. Lastly, recommendations include new developments in outreach and enrollment to target older homeless individuals to help them consistently access the health system as well as other health-related resources.

Implications

Perceived barriers did not appear to be major concerns to the participants in this study; neither were health needs expressed as not being met. Furthermore, homelessness and health care access were not spoken of in the context of linked entities. Limited literature revealed huge gaps in knowledge between the new homeless, chronic homeless, and social disengagement. Findings in this study on the experiences and attitudes of older homeless women toward health care access uncovered completely different experiences and attitudes from what literature proposed and society deems as traditional homelessness. An examination of literature revealed that limited research is available on how demographically identified homeless populations perceive their personal needs, challenges, and barriers to health care system access (Knopf-Amelung, 2013). Additionally, current health care access frameworks do not adequately theorize or deliberate on the public health model and how it can positively impact health related services (Derose, Gresenz, & Ringel, 2011). The purpose of this study was to gain an understanding of older homeless women, their experiences, beliefs, and attitudes toward health care access as well as,

help bridge knowledge gaps between the new homeless, chronic homeless, and social disengagement among the older homeless.

Research determined that frailty screening would be useful to guide medical providers and health agencies in creating health-promoting activities for older homeless individuals especially women (Grenier, et al., 2013; McInnes, Li, & Hogan, 2013; Salem et al., 2013). Collectively participants in this study shared good experiences, expressed gratitude, and eagerness to share their individual story. The knowledge gained from the participant interviews generated potential factors on information that can help create reliable ways to better serve communities with older homeless individuals. Public health organizations and agencies represent various ways to identify and address disparities in health care access (Derose, Gresenz, & Ringel, 2011). Positive social change can be realized through broadening the understanding and producing worthy causes that motivate decision makers on leveling the field of societal imbalances. Supporting increased activity for health care access can promote improved health, encouragement, and manageable life balance (Donovan et al., 2010; Oudshoorn, et al., 2013).

Conclusion

Additional research on new homeless older women can have a great impact on the way homelessness is currently viewed by policymakers, public health, and health care leaders as well as, society in general. The experiences and attitudes of the new homeless toward health care access can provide invaluable insights into challenges encountered when dealing with unstable housing situations and heightened health care needs. Furthermore, new knowledge can be designed to reveal age, gender, nutrition deficiencies, homelessness, levels of resilience, and

health system usage through bridging information between medical facilities, homeless resource centers, and shelter facilities. Even though, participants in this study perceived barriers as tolerable, they expressed a need for improvement. A clearer understanding of the experiences, beliefs, attitudes, and perceptions of older homeless women can impact needed support with health care access and shine a brighter light on unmet health needs yet to be uncovered. The existing built environments around shelters, resources, and health care evidence a need to separate and categorize vulnerable populations of homeless individuals. Results of this study can also inform on how to shift public and persuasive support methods to meet changing health needs and desires of older homeless individuals. Looking backward and pinpointing links to resilience with frailties that plague older homeless populations can produce considerable insights to existing information.

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Appendix A: Letter of Cooperation

Letter of Cooperation

Justa Center
1001 W. Jefferson St.
Phoenix, AZ 85007

Date November 7, 2017

Dear Mary Ann Mueller

Based on my review of your research proposal, I give permission for you to conduct the study entitled Experiences and Attitudes of Older Homeless Women Toward Health Care Access within the Justa Center. As part of this study, I authorize you to perform data collection by conducting face-to-face interviews of written and recorded participant experiences, member-checking, transcript reviews, follow-up procedures, and dissemination activity results. Individuals' participation will be voluntary and at their own discretion.

We understand that our organization's responsibilities include: posting the recruitment flyers on our premises and provide space for the interviews. We reserve the right to withdraw from the study at any time if our circumstances change.

I confirm that I am authorized to approve research in this setting and that this plan complies with the organization's policies.

I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the student's supervising faculty/staff without permission from the Walden University IRB.

Sincerely,

Authorization Official:

Contact Information: Office: 602-254-6524

Walden University policy on electronic signatures: An electronic signature is just as valid as a written signature as long as both parties have agreed to conduct the transaction electronically. Electronic signatures are regulated by the Uniform Electronic Transactions Act. Electronic signatures are only valid when the signer is either (a) the sender of the email, or (b) copied on the email containing the signed document. Legally an "electronic signature" can be the person's typed name, their email address, or any other identifying marker. Walden University staff verify any electronic signatures that do not originate from a password-protected source (i.e., an email address officially on file with Walden).

Appendix B: Interview Guide

Let's begin with demographic questions about you.
Are you 45 or above? Have you ever been married or divorced? Do you have children? Are you a native of AZ? Before coming to this facility did you have a job, or did you come from another facility? What is your highest level of education? How long have you been in an unstable housing situation?

Now, I will ask you a series of questions about your experiences and feelings toward health care while being in an unsheltered situation. You are welcome to choose not to answer questions that I ask. You may also stop the interview at any time.

Research / Interview Questions

Research Question 1: What are the experiences, beliefs, and perspectives of older homeless women toward health care access?	Interview Questions: 1. What are your thoughts about health care access? 2. How do you personally seek health care? 3. What has been some of your experiences with seeking health care while in an unstable housing situation? 4. What do you think would encourage you to seek health care when you want to? Probes: 1. Can you tell me more about …? 2. Can we go back to …? 3. Can you repeat what you just said about …? 4. What did you mean …? 5. Would you explain …?

Research Question 2: What do older homeless women perceive to be barriers in accessing health care?	Interview Questions: 1. What are some things that would keep you from seeking health care services? 2. What are your thoughts about seeking help if you were having problems getting health care? 3. How would you go about getting help to get the health care you need? Probes: 1. Can you tell me more about …? 2. Can we go back to …? 3. Can you repeat what you just said about …? 4. What did you mean …? 5. Would you explain …?
Research Question 3: What do older homeless women perceive as enablers toward accessing health care?	Interview Questions: 1. What do you think would help make access to health care easier to get? 2. What are your thoughts about asking for help from people who work in health centers? 3. What has been your experience with asking for health information? Probes: 1. Can you tell me more about …? 2. Can we go back to …? 3. Can you repeat what you just said about …? 4. What did you mean …? 5. Would you explain …?
Research Question 4: How do older homeless women perceive the personal use of health care services as linked toward their health?	Interview Questions: 1. What do you think about being able to find or access health care?

	2. What are your thoughts about health care workers' ability to help you? 3. What are your thoughts about the health information you receive? 4. What have been your experiences with contacting a health center after you've received health care services? Probes: 1. Can you tell me more about …? 2. Can we go back to …? 3. Can you repeat what you just said about …? 4. What did you mean …? 5. Would you explain …?

Appendix C: Informational Flyer for Recruitment

Female Volunteers Age 45 years old or older Needed For Research On personal

Experiences With Health Care System Access

I (Mary Ann Mueller) am looking for female volunteers to be interviewed for a study on experiences with health care system access who are 45 years old or older in Maricopa County Arizona

As a participant in this survey, you will be asked questions about your own personal beliefs and experiences with health care system access. The interview and member checking process can take up to an hour and a half here at The JUSTA Center, 1001 W. Jefferson St., Phoenix, AZ 85007. If you are interested in this study, please see the facility representative for additional information and participation guidelines!

"I can only include women in the study who are not currently in treatment for substance abuse, alcohol abuse, or a mental disorder."

Thank you,

Mary Ann Mueller (email: mary.mueller@waldenu.edu … or … 509-392-9457)

Appendix D: Script for Participant Interviews

Script for Participant Interview

Hello, my name is Mary Ann Mueller. I am a Walden University student. As part of my studies in Public Health, I am conducting this research study about the experiences, beliefs, and attitudes of older homeless women toward health care access who are 45 years of age and older.

I have a couple of interview questions that will be used to help guide the interview. This interview will take about an hour and a half of your time. Your participation is entirely voluntary; you can skip any parts of the guiding questions that you don't want to talk about. No personally identifying information will be collected except on the consent form which allows me to interview you. All collected consent forms will be kept strictly confidential and in my locked files. I will only use collected data in my research study report with participant identifiers such as participant 1 in the format of P1, P2, P3, and so on.

I will only use collected data in my research study report. The data files will be maintained only by me for 5 years to meet the Walden University archive requirements and then the files will be destroyed.

Do you have any questions about the research study?

Upfront I want to thank you in advance for your participation in this research study. If you have any questions later on you may reach me by phone or email (see your copy of the consent form).

Are you ready to begin?

Introduction

The focus of this interview is to understand more about your experiences and attitude towards health care access.

I consider you the expert at sharing your experiences and attitude about the topic, so there are no wrong answers or responses in this interview. When responding please try to focus on the details of your experiences and how you feel about those experiences. It may help to think about the last time you used health care services. It may also help to try to think of your experiences with health care access as if it was yesterday. Also, please feel free to be totally honest; what you say about health care access is strictly confidential.

Are there any questions?